City of Atlanta

Understanding Your Benefits

RETIRED EMPLOYEE ENROLLMENT GUIDE

September 1, 2011—August 31, 2012

You may now enroll online with Employee Self Service. See instructions on Pg 12.

This open enrollment selection will be in effect from 09/01/2011 through 08/31/2012.

You MUST complete and return an application if you are currently not covered by a City Plan, changing coverage, adding a dependent or are required to provide documentation.

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HOW TO USE THIS BOOKLET

How to Use This Booklet

This book presents basic information about a wide range of options. It is written as a starting point to lay out possibilities for your consideration. You will need to explore in detail the plans of greatest interest to be sure that you have relevant, up-to-date facts before making a decision. As you go through your benefits booklet, you will find guidelines designed to help you analyze your benefits. If you cannot find the answers in this booklet, call your carrier and request additional information. You should try to attend an Open Enrollment Meeting. Even if you already have coverage you may desire a better understanding of that coverage. This booklet will instruct you on how to protect yourself and your family in the event your needs change. It identifies guidelines to use in comparing plans when you are selecting insurance. The benefits booklet also explains how to adjust your coverage to reflect major life changes such as a new baby, marriage, divorce, leaving the City, retirement, and/or the death of a loved one.

Getting the Most From Your Benefits

Revolutionary changes are taking place in the design and implementation of health insurance. This year, the City is offering one Health Maintenance Organization (HMO), one Point of Service (POS) and two Medicare Managed Care plans. Because of constant changes and the rising cost of health care, retirees need more information regarding health and life insurance benefits in order to deal with the variety of choices you are asked to make.

Becoming knowledgeable and making the most effective decisions regarding your benefits is not easy, but insurance is important, but the effort is definitely worthwhile. This booklet provides the information necessary to answer the benefits questions by offering a clear picture of all benefits provided by the City of Atlanta for you – the retiree. One of the first necessary steps to take is to learn which insurance plans your physician will accept in 2011–2012 and the provisions of your particular carrier. Once you understand your coverage, you will gain the confidence to take control of your benefits.

Health Terms

The list of terms in the *Glossary* section, located in the back of this book, may be helpful. Various health care terms and options are defined and explained, such as “deductibles,” “coinsurance,” “UCR,” and more. This will help you become familiar with some of the language of the benefits industry and health insurance providers.

Select Carefully

The information in this booklet offers you the information you must have to be an effective manager of your benefits. After all, who cares more about conserving your resources than you? Choices available are for the financial protection of retirees and their dependents. Please review your booklet carefully before making your final selection. Remember, only you – the retiree – are capable of making the most beneficial decision for you.

NOTE TO MEDICARE PARTICIPANTS

SPECIAL NOTE TO RETIREES

If you and/or your spouse are new enrollees to Medicare Parts A and B, you must attach a copy of your and/or your spouse's Medicare card to the Open Enrollment Application and enroll in either Kaiser Senior Advantage or BCBS-Anthem Medicare Preferred (PPO).

If you live in the State of Georgia, the following selections are available for the plan year 09/01/2011 - 08/31/2012:

Kaiser Permanente will continue to offer **SENIOR ADVANTAGE** to retirees who have both parts A and B of Medicare and live within their Senior Advantage Service Area, which includes the same counties as the Kaiser HMO Plan.

If you are a current Kaiser Permanente **SENIOR ADVANTAGE** member, Kaiser Permanente will automatically serve as your Medicare Part D provider. If you are a new member who selects Senior Advantage as your retiree health care plan option for 2011–2012, your application will include Part D enrollment information. For additional information regarding this benefit, please call Kaiser Permanente Customer Service at **404-233-3700**.

BCBS-Anthem Medicare Preferred (PPO), plan offered, to retirees and/or spouses who have both parts A and B of Medicare. The national network will include all providers accepting Medicare and willing to accept BCBS – Anthem Medicare Preferred (PPO) reimbursements and rules.

To participate in the a Medicare Advantage Plan, you will have to complete a separate application which will be mailed to your home by the insurance carrier. In the future, if you want to change from Medicare Advantage Plan to another Medicare Advantage Plan, you must notify the insurance division in writing.

PLEASE NOTE:

If you are Medicare eligible, you **must** enroll in Parts A and B of Medicare and enroll in a Medicare Advantage Plan. If you are not Medicare eligible, you may continue with the City's non Medicare Plans.

If you sign up for any **Medicare Advantage Plan** (other than Senior Advantage offered by Kaiser or BCBS-Anthem Medicare Preferred (PPO) that may be offered to you directly by various vendors, including just Medicare Part D for prescription drugs, **YOUR COVERAGE THROUGH THE CITY OF ATLANTA WILL BE TERMINATED**. If you have any questions about this, please call the DHR – Insurance Division at **(404) 330-6036** before signing up for another medical plan of any type.

IMPORTANT CONTACT INFORMATION

DHR Insurance Division 68 Mitchell St SW Suite 2120 Atlanta, GA 30303 Phone: 404.330.6036 Fax: 404.658.6585	**Employee Wellness Center** 55 Trinity Ave SW 5TH Floor Atlanta, GA 30303 Phone: 404.865.8496 or 404.865.8497
GEM Group (General Pension Fund) 225 Peachtree St Suite 1460 Atlanta, GA 30303 Phone: 404.525.4191 www.gemgrouplp.com	**ASI (Fire & Police Pension Fund)** 2187 Northlake Pkwy Suite 106 Bldg 9 Tucker, GA 30084 Phone: 770.934.3953 www.apba.com
Retirement Services 55 Trinity Ave SW Suite 1600 Atlanta, GA 30335 Phone: 404.330.6260	**Employee Assistance Program** 818 Pollard Blvd Suite 301 B Atlanta, GA 30315 Phone: 404.658.7397

Benefits Providers

Blue Cross Blue Shield 1-800-368-0766 www.bcbsga.com **BCBS-Anthem Medicare Preferred (PPO)** 1-800-810-BLUE 1-800-810-2583	**Kaiser Permanente (HMO)** 1-888-865-5813 404-261-2590 www.kp.org
Cigna Dental 1-800-244-6224 www.mycigna.com	**Humana Specialty Benefits Dental** 1-800-342-5209 www.humanaspecialtybenefits.com
OptumHealth Vision 1-800-638-3120 www.myoptumhealthvision.com	**AFLAC (Flex Spending & Supplemental Insurance)** 770-449-5215 www.aflac.com
Greater Georgia Life Insurance 1-800-552-2137 www.bcbsga.com	**ING Deferred Compensation** 1-800-525-4225 www.ingretirementplans.com
ICMA Retirement Corporation 1-800-669-7400 www.icmarc.org	**Nationwide Retirement Solutions** 1-877-677-3678 www.nrstoru.com

OPEN ENROLLMENT (OE) INFORMATION

OPEN ENROLLMENT

The annual Open Enrollment period for the City of Atlanta is **June 27 – July 18**. The Medical, Dental, Vision, and Group Term Life Insurance benefit programs offered in the new plan year are the same as the 2010 – 2011 plan year. However, there are coverage changes reflecting evidence based medicine up-dates and provisions of the Health Care and Education Affordability Reconciliation Act of 2010, which is summarized in this enrollment guide.

Review the plan offerings, and select which programs you and your dependents request. The options you select will be effective September 1, 2011. You must make all changes during the **Open Enrollment Period of June 27 – July 18** which will remain in effect until August 31, 2012, unless you have a qualifying life event. If you do not wish to make changes for the new benefit plan year, you are not required to return an application. All Open Enrollment Applications with benefit changes are due to the Department of Human Resources (DHR) Insurance Division **no later than July 18, 2011**. If you are completing the application online, Open Enrollment will close at 11:59 p.m. July 18, 2011.

Online Self-Service Access

Online self-service open enrollment access is available at the City's web site www.atlantaga.gov. Online access and self-service enrollment assistance is available throughout the OE period at City Hall Tower, DHR, Suite 2120. The Office of Employee Benefits staff is available from 8:30 a.m. – 5:30 p.m. **Access to online self-service will be unavailable June 29th and July 13th.**

Attend an Open Enrollment (OE) Period Information Forum

Would you like to know more about your 2011–2012 benefits? The Insurance Division will be on location to answer your questions. Speak with the benefit program providers face-to-face at an OE Information Forum near you. The calendar below shows the dates and times for the Information Forums.

OE Period Events Calendar

June – July 2011

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
27 Open Enrollment Begins	**28** City Hall Old Council Chambers 10 am – 2 pm	**29** Public Safety Bldg. JOC Conference Rm 10 am – 3 pm	**30** Airport Gateway Conf. Rm 10 am – 12 pm Airport Technical Center 2 pm – 4 pm	**1**	**2**
4 Holiday	**5**	**6**	**7** Airport Gateway Conf. Rm 10 am – 12 pm Airport Technical Center 2 pm – 4 pm	**8** Atlanta Civic Center Piedmont Rm 10 am – 3 pm	**9**
11	**12**	**13** Public Safety Bldg. JOC Conference Rm 12 pm – 4 pm	**14** Atlanta Civic Center Piedmont Rm 10 am – 3 pm	**15**	**16**
18 City Hall Old Council Chambers 10 am – 2 pm **Open Enrollment Ends**					

Forum Locations:

- Old Council Chamber, City Hall Tower, 68 Mitchell St. SW, Atlanta, GA 30303
- Atlanta Civic Center, Piedmont Room, 395 Piedmont Avenue, N.E. (Free parking available)
- Hartsfield-Jackson Development Campus, Program Technical Center, 1255 South Loop Rd. (Free parking available)
- Hartsfield-Jackson Airport, Gateway. Boeing, Cesna Conference Room, 4th Floor Atrium - 6000 N. Terminal Parkway
- JOC Conference Rm, Public Safety Bldg., 226 Peachtree St., SW, Atlanta, GA 30303

BENEFIT HIGHLIGHTS

Kaiser HMO Plan:

- Primary Care Physician (PCP) visit copay increased from **$10.00 to $15.00**
- Deductible - $300 Single/$900 Family for all **inpatient/outpatient services.** 100% coverage after deductible is met.
- Emergency Room visit copay increased from **$100.00 to $150.00**
- Preventive Care visits will be covered at **100% (No office copay required)**
  - Immunizations
  - Annual Gynecology Exam
  - Prostate Exam
  - Annual Adult Physicals
  - Well-Child Care Physicals
  - Mammograms
- Health Works Wellness Plan – up to $200.00 in rewards for participation in total Health Assessment and Health Lifestyle Programs.

Blue Cross Blue Shield POS Plan:

- Specialty Care Physician (SCP) office visit copay increased from **$25.00 to $30.00**
- Deductive – In-Network services - $300 Single/$900 Family **for all inpatient/outpatient services.** 100% coverage after deductible.
- Deductible – Out-of-Network - $600 Single/$1,800 Family for all inpatient/outpatient services. 100% coverage after out-of-pocket calendar year maximum is met.
- Emergency Room visit copay increased from **$75.00 to $150.00**
- Preventive Care Visits – covered at **100% (no office copay required)**
  - Immunizations
  - Annual Gynecology Exam
  - Prostate Exam
  - Annual Adult Physicals
  - Well-Child Care Physicals
  - Mammograms
- **Diabetes Management Program** – offers employees/retirees/dependents incentive to comply with structured program (zero copay for diabetic supplies and medication when compliant with program rules).
- PPO Wrap Network available for retirees residing outside the BCBS Georgia Service area
- **Smart Value has changed to <u>BCBS – Anthem Medicare Preferred (PPO)</u>**

HEALTH REFORM PROVISIONS

Health Reform Key Provisions That Take Effect Immediately & COA Health Plan

Key Provision / Takes Effect	COA Health Plan
NO DISCRIMINATION AGAINST CHILDREN WITH PRE-EXISTING CONDITIONS—Prohibits new health plans in all markets plus grandfathered group health plans from denying coverage to children with pre-existing conditions. **Effective 6 months after enactment.** (Beginning in 2014, this prohibition would apply to all persons.)	All reference to BCBSGA POS pre-existing conditions waiting periods will be removed from plan. KP HMO has none.
ENDS RESCISSIONS—Bans insurance companies from dropping people from coverage when they get sick **Effective 6 months after enactment.**	NO CHANGE REQUIRED
BEGINS TO CLOSE THE MEDICARE PART D DONUT HOLE—Provides a $250 rebate to Medicare beneficiaries who hit the donut hole in 2010. **Effective for calendar year 2010.** (Beginning in 2011, institutes a 50% discount on prescription drugs in the donut hole; also completely closes the donut hole by 2020.)	NO CHANGE REQUIRED BCBS-Anthem Medicare Preferred (PPO) & Kaiser Permanente (KP) Senior Advantage (SrA) has no Part D Donut Hole.
FREE PREVENTIVE CARE UNDER MEDICARE—Eliminates co-payments for preventive services and exempts preventive services from deductibles under the Medicare program. **Effective beginning January 1, 2011.**	BCBS SV & KP SrA to implement effective January 1, 2011.
EXTENDS COVERAGE FOR YOUNG PEOPLE UP TO 26TH BIRTHDAY THROUGH PARENTS' INSURANCE—Requires new health plans and certain grandfathered plans to allow young people up to their 26th birthday to remain on their parents' insurance policy, at the parents' choice. **Effective 6 months after enactment.**	Effective with new plan year starting September 1, 2011.
BANS LIFETIME LIMITS ON COVERAGE—Prohibits health insurance companies from placing lifetime caps on coverage. **Effective 6 months after enactment.**	NO CHANGE REQUIRED
BANS RESTRICTIVE ANNUAL LIMITS ON COVERAGE—Tightly restricts the use of annual limits to ensure access to needed care in all new plans and grandfathered group health plans. These tight restrictions will be defined by HHS. **Effective 6 months after enactment.** (Beginning in 2014, the use of any annual limits would be prohibited for all new plans and grandfathered group health plans.)	NO CHANGE REQUIRED
FREE PREVENTIVE CARE UNDER NEW PRIVATE PLANS—Requires new private plans to cover preventive services with no co-payments and with preventive services being exempt from deductibles. **Effective 6 months after enactment.**	Effective with new plan year starting September 1, 2011.
NEW, INDEPENDENT APPEALS PROCESS—Ensures consumers in new plans have access to an effective internal and external appeals process to appeal decisions by their health insurance plan. **Effective 6 months after enactment.**	Effective with new plan year starting September 1, 2011.
PROHIBITS DISCRIMINATION BASED ON SALARY—Prohibits new group health plans from establishing any eligibility rules for health care coverage that have the effect of discriminating in favor of higher wage employees. **Effective 6 months after enactment.**	NO CHANGE REQUIRED
HEALTH INSURANCE CONSUMER INFORMATION—Provides aid to states in establishing offices of health insurance consumer assistance in order to help individuals with the filing of complaints and appeals.	www.Georgiahealthinfo.gov

ELIGIBILITY

Benefits Eligibility

Retirees, their surviving beneficiaries and their dependents are eligible to enroll in the City of Atlanta's health and dental plans. Of course, dependents must meet certain eligibility criteria to be considered. The following is a list of eligible dependents:

- A spouse (a husband or wife who is joined in marriage to a retiree by a ceremony recognized by the laws of the State of Georgia)
- A domestic partner (registered with the City of Atlanta)
- A dependent child through 26 years of age. Coverage ends at the end of the month the child reaches age 26.
- A legally adopted child under age 26 or a child for whom you have guardianship **(permanent or deemed permanent for insurance purposes)**
- A legally adopted child under age 26 or a child for whom you have guardianship (permanent or A step-child under age 26 permanently residing with the retiree and supported by the retiree A child under age 26 and receiving court-ordered support A child 26 years or older who is incapable of self-support due to mental or physical disability, and who
- Has a permanent disability
- A child, after attaining age 26, who is receiving a Pension Check as a Surviving Beneficiary and is covered by the City of Atlanta Group Plan must provide Full-Time Student Documentation. When eligibility for Pension ends due to age or change in School Enrollment Status, contact the DHR Insurance Division at **(404) 330-6036** to continue coverage.
- As a surviving spouse, if you terminate coverage you will not be able to re-enroll in the City of Atlanta's Benefits Plan.
- Documentation is needed if the retiree is adding a dependent, making changes on a dependent's status.
- If both you and your spouse are insured under a City of Atlanta health/dental plan as an employee or retiree, your children may be insured as dependents of either you or your spouse, for health/dental coverage.
- **No city employee/retiree may be the dependent of another employee/retiree for health, vision or dental insurance.** However, for Life Insurance, a retiree may cover his/her spouse even if the spouse is an employee/retiree. Children may be insured by both parents for life insurance coverage.
- Please remember to submit supporting documentation to add your dependents. If the Insurance Division does not receive your documentation your dependents will not be added.

DEPENDENT ELIGIBILITY DOCUMENTATION REQUIREMENTS

DEPENDENTS	DOCUMENTATION REQUIRED
For Spouse	• Copy of Marriage Certificate. If previously married, death certificate or divorce decree.
For Removal of Spouse/Child	• None at Open Enrollment. Court Decree **within 31 days** of Decree during the contract year.
For Natural Child(ren)	• Child's Birth Certificate (showing a parent-child relationship to retiree and/or spouse)
For Adopted Child(ren)	• Placement Papers signed by the Courts.
For Disabled Child (26 yrs and older)	• Physician Verification of permanent disability.
Foreign Adoptions	• Adoption Papers signed by the Courts • Visa showing date of entry to USA.
For Step Child(ren)	• Child's Birth Certificate (showing parent-child relationship with retiree's spouse). • Copy of Marriage Certificate.
For Court-Ordered Support	• State Affidavit. • Copy of signed Court Order requiring retiree to provide support for health coverage.
For Guardianship	• Court ordered guardianship deemed permanent for insurance purposes.
For Domestic Partner	• City of Atlanta Affidavit of Financial Reliance (Notarized) within 31 days of approval.
For Termination of Domestic Partner	• None at Open Enrollment. City of Atlanta Notice of Termination **within 31 days** of termination during the contract year.

Social Security number and date of birth must be provided for all dependents. Failure to submit the dependent's Social Security number will result in termination/denial of coverage (exceptions: newborns age 6 months or less).

Documentation also applies to life insurance coverage.

No documentation is required at Open Enrollment to delete a dependent.

All documentation should contain the retiree's name and Social Security number.

WELLNESS AT WORK

The Department of Human Resources manages a comprehensive health and wellness program for the City's active and retired employees and their families. For more info on the activities listed below contact the Employee Health Center at 404.865.8496.

You should also log on to your healthcare providers website and complete a Health Risk Assessment form. The assessment will assist you in determining which activity will suit your health care needs.

Kaiser Members: **www.kp.org**

Blue Cross Blue Shield members: **www.bcbsga.com**

Employee Fitness Center- this free, state of the art fitness center is located in City Hall on the 4th floor. The facility has universal weight equipment machines, aerobic equipment, a walking track and locker room facilities with showers.

Employee Health Center- Staffed by a full-time Nurse Practitioner and Medical Technician, this facility offers free preventative and minor medical services and a variety of health related educational materials. The health center's medical staff focuses on health screenings - blood pressure, blood sugar, and cholesterol levels. This initiative is designed to facilitate early disease detection so that employees and their physicians can get a head start in addressing critical issues and make lifestyle changes as necessary. Preventive and educational visits to field operations worksites and treatment of high cost medical conditions (i.e. diabetes, hypertension and asthma) will be key initiative for 2011–2012.

Lunch and Learn Series- DHR, in partnership with contracted health insurance vendors and community providers, sponsors a monthly lunch and learn series for employees. Monthly topics focus primarily on key health issues identified by the American Medical Association and the National Institutes of Health. Health insurance vendors provide nutritious lunches while employees discuss various medical concerns with leading medical professionals. Such topic include: breast cancer, cardiovascular health, HIV/AIDS awareness, blindness prevention, diabetes prevention and management, nutritious foods and healthy cooking, fitness training, and dental care. The series is held every third Wednesday of the month.

Disease Management- Contracted insurance vendors manage chronic diseases such as diabetes, heart disease, coronary artery disease (including circulatory restrictions and strokes), musculoskeletal disorders (including lower back pain) and digestive disorders (the top five chronic diseases prevalent in our population). The department is working to reach not only active employees but also partnering with other agencies to reach out to retired employees. At the same time, DHR is educating employees to help them be more aware of these illnesses and the health disparities leading to earlier and more frequent prevalence of these diseases.

BENEFITS
SELF SERVICE INSTRUCTIONS

Enrolling into your COA Benefits using Oracle Self Service

Benefits Open Enrollment can now be completed online! There are six main parts to this process and each is outlined in this step by step guide.

1. Access the OAB Website at www.atlantaga.gov
2. Click on **Departments**- then click **Human Resources**
3. Click on **Employee & Retiree Benefits**
4. Click on the **Open Enrollment (OE) Quick Link**
5. Enter your username: **Employee ID** and **Password** *(If you need an oracle password and your employee ID number please contact the help desk at 404.330.6474).*
6. In the navigator tool click on **COA Employee Self Service** then click on **Benefits**

Page 1: Dependents and Beneficiaries
This is where you will enter anyone you want to list as a dependent and or beneficiaries, if they are not there.

7. Click Add Another Person
8. Enter the person's **Name and Relationship**.
9. Enter their Address Information, or if they share the same residence as you, check the shared residence box.
10. Enter the Required Information
11. When finished, click Apply
12. Repeat steps 7-10 as many times as necessary to add Dependents and beneficiaries.
13. When you are ready to continue, click Next.

Page 2: Benefits Enrollments
This page will show an overview of available benefits and your current status. To enroll move to step 14.

14. Click Update Benefits
15. Check the boxes ☑ Add Dependents and Beneficiaries next to the benefits you want to select. You can add dependents and beneficiaries at any time by clicking the button.
16. When you have made your selections and are ready to continue, click Next.

Page 3:Update Benefits – Cover Dependents
This is where you will choose which dependents will be covered for your selected benefits.

17. Click on the box next to their name if you want them to be covered under this corresponding benefit.
18. When you have made your selections and are ready to continue, click Next

Page 4: Update Beneficiaries: Add Beneficiaries
This is where you can specify what percentage of any insurance payouts you want each of your beneficiaries to receive.

19. Choose which beneficiaries would receive anything as A primary recipient (for example, will your spouse receive 100% of the benefit if something happens to you)?
20. Choose which beneficiaries would receive anything as a contingent recipient (for example, what will your children receive if something happens to you and your primary recipient)?
21. To recalculate your total, click Recalculate. Both the primary and contingent percentages should equal 100%.
22. Repeat for additional policies listed.
23. When you are ready to continue, click Next

Page 5: Add Primary Care Providers
24. Depending on the plans you have selected for your medical insurance, you may be asked to enter your primary care provider's ID, name and specialty.
25. When you are ready to continue, click Next.

Page 6: Confirmation Page
This page allows you to review everything you have selected.

- If you want a printable version of this page, click Printable Page.
- If you want a Confirmation Statement, click Confirmation Statement.

26. When finished, click Finish.

You will then see another review of what you have selected.

If you want to make any changes, click Update Benefits and follow from step 14.

You're Done!

NON-MEDICARE RETIREES HEALTH PLAN COMPARISON

Plan Provisions	BCBS of GA - Current Plan Design		Kaiser HMO
	In-Network	Out- of- Network	
Lifetime Maximum	Unlimited	$1,000,000	Unlimited
Deductible			
☐ Individual	$300	$600	$300
☐ Family	$900	$1,800	$900
Out-of-Pocket			
☐ Individual	$2,000	$4,000	$2,000
☐ Family	$6,000	$12,000	$6,000
Coinsurance	100%	70%	N/A
Preventive Care			
☐ Immunizations	100% no copay	70% after deductible	$15 Copay / (well-child care covered @ 100%)
☐ Pap Smear/Mammography/Prostate Screening	100% no copay	70% after deductible	100% no copay
☐ Routine Physicals	100% no copay	70% after deductible	$15 copay
Office Visits			
☐ Primary Care	$15 copay	70% after deductible	$15 copay
☐ Specialists	$30 copay	70% after deductible	$30 copay
Emergency Services			
☐ Hospital (Waived if admitted)	$150 copay	$150 copay	$150 copay
Inpatient Hospital	100% after deductible	70% after deductible	100% after deductible
Outpatient Hospital Services			
☐ Hospital Charges	100% after deductible	70% after deductible	100% after deductible
Mental Health/Substance Abuse			
☐ Inpatient Mental Health Treatment	Plan pays @ 100% (unlimited visits)	70% after deductible	100% covered after deductible
☐ Outpatient Mental Health Treatment	$30 copay (40 days per year max)	70% after deductible	$15 copay (unlimited visits)
Ambulance Service	$150 copay	70% after deductible	$150 copay
Skilled Nursing Facility (100 day max)	No Charge	70% after deductible	No Charge
Home Health Care	No Charge	70% after deductible	120 visits max
Hospice	No Charge	70% after deductible	No Charge
Prescription Drugs			
☐ Generic	$10	70% after deductible	$10
☐ Brand	$25		$30
☐ Brand Non-Preferred	$40		N/A
☐ Mail Order	2x Retail Copay	Not Covered	90 days supply @ 2 times Kaiser RX Copay
Vision			
☐ Eye Exam once every 12 months	$30 copay	70% after deductible	$30 copay
☐ Frames and Lenses once every 24 months	Discount Plan		Discount Plan

BLUECHOICE POS PLAN
BENEFITS SUMMARY (NON-MEDICARE ELIGIBLE)
09/01/2011 - 08/31/2012

Primary Care Physician

A primary care physician, or PCP, is a doctor who specializes in family or general practice, internal medicine or pediatrics and participates in the BlueChoice Option network. Each BlueChoice Option member must select a PCP. Your PCP is responsible for providing or coordinating necessary care for you 24 hours per day, 7 days a week. For additional medical information call BlueChoice On-Call, available 24 hours per day, 7 days a week.

In-Network versus Out-of-Network

As a BlueChoice Option member, you have the ability to receive services either from providers in the BlueChoice Option network or outside this network. Generally, you will pay less out of your own pocket if you elect in-network services.

- ***In-Network Services*** are those services that are either provided or coordinated by your PCP. Some services do not require PCP coordination. Please keep in mind that even though a referral is not required for certain services, you must select a provider from the network directory to receive in-network benefits. Services that do not require a PCP referral include:
  - *OB/GYN* services for the treatment of an obstetrical or gynecological-related condition.
  - *Covered Vision Care Services* – from a network ophthalmologist or optometrist (Routine vision services may not be covered under your policy – if you do not know if you have routine vision coverage, please call customer service at **(800) 368-0766).**
  - *Dermatological care* for skin-related conditions.
  - *Mental Health or Substance Abuse Benefits* – You may contact Blue Cross/Blue Shield of Georgia Behavioral Health directly at **(800) 368-0766**, without contacting your PCP.

Pre-Existing Condition Limitation and Credit for Prior Coverage

There is no pre-existing condition limitation.

Emergencies

If you have a medical emergency, call 911 or proceed immediately to the nearest hospital emergency room. A "medical emergency" is defined as, "a condition or recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in their health being in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ."

Prescription Drugs

BlueChoice Option offers prescription drug coverage through a pharmacy network that includes many national pharmacy chains and select local pharmacies. Coverage is provided according to our preferred drug formulary for prescriptions written by a network physician and filled at a network pharmacy. Out-of-network prescriptions are also subject to the preferred drug formulary.

Summary of Limitations and Exclusions

Your *Summary Plan Description* will provide you with complete benefit coverage information. Some key limitations and exclusions, however, are listed below:

- Care or treatment that is not medically necessary
- Cosmetic surgery, except to restore function altered by disease or trauma
- Dental care and oral surgery; except for accidental injury to natural teeth, treatment of TMJ and extraction of impacted teeth
- Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs.
- Occupational related illness or injury
- Treatment, drugs or supplies considered experimental or investigational
- Surgical or medical care for: artificial insemination, invitro fertilization, reversal of voluntary sterilization, radial keratotomy, learning disabilities, mental retardation, hyperkinetic syndrome or autistic disease of childhood
- Smoking cessation products

BLUECHOICE POS PLAN
BENEFITS SUMMARY (NON-MEDICARE ELIGIBLE)
09/01/2011 - 08/31/2012 *(cont'd)*

Prior Authorization

Your PCP must coordinate most in-network services. For in-network services, your PCP (or the specialist to whom you were referred by your PCP) will be responsible for ensuring that any surgical procedures or inpatient admissions obtain the necessary prior authorization. For out-of-network services, you should be sure that Blue Cross Blue Shield Healthcare Plan of Georgia has authorized the following procedures prior to these services being rendered:

- Home health care services
- All outpatient surgery, including laproscopic and arthroscopic procedures
- Durable Medical Equipment over $250
- MRIs
- EMGs
- All scopes, including endoscopy and colonoscopy
- Myelography
- Cardiac catheterization

Note: This list is subject to change.

If you receive out-of-network treatment and prior authorization was not obtained, all charges will be denied. You, the member, will be responsible for all charges.

Vision

The coverage will be limited to one (1) eye examination for corrective lenses per member in a 12 month period, (corrective lenses is intended to include contacts as well as glasses). Office visit co-payment should be the same as for any other specialist $30.00 in-network and 70% of UCR, after the deductible, out-of-network.

The City will not cover lenses, frames, disposable or hard contact lenses and POS Members will be encouraged to utilize the BCBS discounted vision program.

Additional Information

Should you need additional information, the resources are your *Provider Directory/Member Guide* and your *Summary Plan Description*. You may also visit our web site at www.bcbsga.com for more information. If you have specific questions that require an answer from our representatives, please call one of the following numbers:

- Customer Service. . . . . **(800) 368-0766**
- Blue Cross/Blue Shield of Georgia Behavioral Health (Mental Health/Substance Abuse Services) . . . . . **(800) 368-0766**
- BlueChoice On-Call. . . . . **(888) 724-2583**

See Summary Plan Description for Complete Details

It is important to keep in mind that this material is a brief outline of benefits and covered services and is not a contract. Please refer to your Summary Plan Description for a complete explanation of covered services, limitations and exclusions.

Condition Management Programs

It really doesn't matter if you or someone on your health benefits plan just found out, or if you've known for a while, we know managing a chronic health condition can sometimes be tricky.

And, if you're trying to manage a health condition such as Asthma, Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, Coronary Artery Disease (CAD) or Diabetes, you'll probably agree that having access to new medical information and advice, tips and online tools specifically designed to help you manage your condition is invaluable. Neonatal Intensive Care Unit (NICU) and Maternity Management are also included. And, that's how using our Condition Management programs can come in handy!

What is it and what's included?

Our Condition Management programs are a service where you can talk with one of our registered nurses 24/7, or you can access information online to find ways to better manage your condition.

When you participate in this program, you have access to:

- Health evaluations and consultations as needed, to help you manage your condition
- Educational materials on prevention, self-monitoring charts, condition-specific care diaries and self-care tips

You'll also gain peace-of-mind because you'll know you have the tools and information you need to begin, or continue, taking control of your health condition. That alone is worth the price of admission; however, this is a free program!

What else?

When you receive something you need, you're happy. And, we believe you'll be happy with the information and tools available in our Condition Management programs. So, don't delay the happy feelings! Give us a call at **(800) 638-4754** to enroll.

BLUECHOICE POS PLAN
BENEFITS SUMMARY (NON-MEDICARE ELIGIBLE)
09/01/2011 - 08/31/2012 *(cont'd)*

In addition to copayments, members are responsible for deductibles, as described below.
Please review the deductible information to know if a deductible applies to a specific covered service.

Members are also responsible for all costs over the plan maximums.
Plan maximums and other important information appear in *italics.*

Each member enrolling in this plan must list a primary care physician on the enrollment application.
When using out-of-network providers, members are responsible for any difference between the allowed amount and actual charges, as well as any copayments and deductibles.

DEDUCTIBLES, MAXIMUMS, ETC.	IN-NETWORK BENEFIT LEVEL	OUT-OF-NETWORK BENEFIT LEVEL
Calendar Year Deductible: *one for employee, one for spouse, one for all eligible children combined*		
– Individual	$300	$600
– Family	$900	$1,800
Coinsurance/Copayments	Plan pays 100%; Member pays copayments as required	Plan pays 70% after deductible; Member pays 30% after deductible
Lifetime Maximum	Unlimited	$1,000,000
Out-of-Pocket Calendar Year Maximum*		
– Individual	$2,000	$4,000
– Family	$6,000	$12,000

* *Maximum of three (3) per family* (one for employee, one for spouse and one for all eligible children combined). The following do not apply to out-of-pocket maximum: deductibles, copayment amounts, non-emergency room copayments, non-covered items and coinsurance for behavioral health/substance abuse. Out-of-Pocket limits are accumulated separately for in-network and out-of- network services.

COVERED SERVICES	IN-NETWORK BENEFIT LEVEL	OUT-OF-NETWORK BENEFIT LEVEL
Office Visits: Preventive Care		
Well-child care, immunizations	100% no copay	Plan pays 70% after deductible
• Periodic health examinations	100% no copay	Plan pays 70% after deductible
• Annual gynecology examination (No PCP referral required – Must use in-network provider for in-network benefits)	100% no copay	Plan pays 70% after deductible
• Adult Annual Physical	100% no copay	Plan pays 70% after deductible (maximum benefit $500)
• Prostate screening	100% no copay	Plan pays 70% after deductible
Illness or Injury		
• Primary Care Physician (PCP) office visit (includes lab, radiology and office surgery)	$15 copayment	Plan pays 70% after deductible
• Primary care physician after hours visit	$25 copayment	Plan pays 70% after deductible
• Specialty care physician office visit (PCP referral required)	$30 copayment	Plan pays 70% after deductible
• Second surgical opinion (PCP referral required)	$30 copayment	Plan pays 70% after deductible
• Allergy care (office visit, testing, serum and allergy shots)	$30 copayment	Plan pays 70% after deductible

BLUECHOICE POS PLAN
BENEFITS SUMMARY (NON-MEDICARE ELIGIBLE)
09/01/2011 - 08/31/2012 *(cont'd)*

COVERED SERVICES	IN-NETWORK BENEFIT LEVEL	OUT-OF-NETWORK BENEFIT LEVEL
• Maternity physician services (prenatal, delivery, postpartum)	$30 copayment at first office visit	Plan pays 70% after deductible
• Vision care services provided by a network ophthalmologist or optometrist for treatment of acute conditions (No PCP referral required)	$30 copayment	Plan pays 70% after deductible
• Services provided by network dermatologists (No PCP referral required)	$30 copayment	Plan pays 70% after deductible
Emergency Room Services		
• Life-threatening illness, serious accidental injury or with a PCP referral	$150 copayment *(waived if admitted)*	$150 copayment *(waived if admitted)*
• Non-emergency use of the emergency room	Not covered	Not covered
Inpatient Services		
• Daily room, board and general nursing care at semi-private room rate; ICU/CCU; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care	Plan pays 100% after deductible *(Subject to $300 Single / $900 Family deductible)*	Plan pays 70% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	Plan pays 100% after deductible *(Subject to $300 Single / $900 Family deductible)*	Plan pays 70% after deductible
Outpatient Services		
• Surgery facility/hospital charges (outside a physician's office)	Plan pays 100% after deductible *(Subject to $300 Single / $900 Family deductible)*	Plan pays 70% after deductible
• Diagnostic X-ray and lab services	Plan pays 100% after deductible *(Subject to $300 Single / $900 Family deductible)*	Plan pays 70% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	Plan pays 100% after deductible *(Subject to $300 Single / $900 Family deductible)*	Plan pays 70% after deductible
Therapy Services	**Calendar year visit limits are combined between in-network and out-of-network**	
• Speech Therapy	$30 copayment; 20-visit calendar year maximum	Plan pays 70% after deductible; 20-visit calendar year maximum
• Physical, occupational therapy	$30 copayment; 20-visit calendar year maximum	Plan pays 70% after deductible; 20-visit calendar year maximum
• Respiratory therapy	Plan pays 100%; 30-visit calendar year maximum	Plan pays 70% after deductible; 30-visit maximum
• Radiation therapy, chemotherapy	Plan pays 100%	Plan pays 70% after deductible

BLUECHOICE POS PLAN
BENEFITS SUMMARY (NON-MEDICARE ELIGIBLE)
09/01/2011 - 08/31/2012 *(cont'd)*

COVERED SERVICES	IN-NETWORK BENEFIT LEVEL	OUT-OF-NETWORK BENEFIT LEVEL
Mental Health/Substance Abuse	**No Primary Care Physician referral required. Services must be authorized by Blue Cross/Blue Shield of Georgia Behavioral Health at (800) 368-0766**	
• Inpatient (unlimited)	Plan pays 100%	Plan pays 70% after deductible
• Outpatient (unlimited)	Plan pays 100%	Plan pays 70% after deductible
Other Services		
• Skilled nursing facility (100 days maximum)	Plan pays 100% after deductible	Plan pays 70% after deductible
• Home HealthCare (40 visits per cal. yr. max.)	Plan pays 100% after deductible	Plan pays 70% after deductible
• Hospice Care *($7,500 maximum)*	Plan pays 100% after deductible	Plan pays 100%
• Ambulance	$100 copayment; Plan pays 100%	Plan pays 70% after deductible
Prescription Drugs		
To receive maximum coverage, have your prescriptions written by a network physician and filled at one of the pharmacies in our network. These include certain local independent pharmacies, as well as many national chain pharmacies: Bi-Lo, CVS, Eckerd, Kmart, Kroger, Publix, Save-Rite, Walgreens, Wal-Mart, Winn-Dixie.	Unless otherwise indicated in the Summary Plan Description, each prescription has a 30-day supply limit. Each mail order maintenance prescription has a 90–day supply limit.	
Retail:		
Generic	$10	Plan pays 70% after the deductible for covered prescriptions at non-participating pharmacies.
Brand Formulary	$25	
Brand Non-Formulary	$40	
Mail order: (Maintenance drugs only)	90-day supply	**NO MAIL ORDER PRESCRIPTIONS ARE AVAILABLE OUT-OF-NETWORK**
Generic	$20	
Brand Formulary	$50	
Brand Non-Formulary	$80	
Vision	The coverage will be limited to one (1) eye examination for corrective lenses per member in a 12 month period, (corrective lenses is intended to include contacts as well as glasses). Office visit co-payment should be the same as for any other specialist $25.00 in-network and 70% of UCR, after the deductible, out-of-network. The City will not cover lenses, frames, disposable or hard contact lenses and POS Members will be encouraged to utilize the BCBS discounted vision program.	

For a full disclosure of all benefits, exclusions and limitations please refer to your Summary Plan Description.

Blue Cross/Blue Shield of Georgia will designate a Primary Care Physician (PCP) for you if you do not list one on your Enrollment Application. You may change your PCP by notifying Blue Cross/Blue Shield of Georgia. If notification is received prior to the 25th, the PCP will change the 1st of the following month. Notification after the 25th will delay the change a month.

GOOD HEALTH IS IN OUR DNA.

For more than 60 years, our message has remained the same: Promote health to prevent illness. This apple-a-day approach helps foster the wellness of our millions of members nationwide.

But we're not just about ensuring health. We want to inspire it. Through care that's personalized to your goals and needs, intuitive technology that brings you closer to your well-being, and a mission that has stood the test of time.

Some people might say, "At least you have your health." At Kaiser Permanente, we prefer to see things this way: If you have your health, you have everything.

Where do I receive medical care?

When you join Kaiser Permanente, you pick your own personal physician from the group of doctors practicing at any of our medical centers. Currently, Kaiser Permanente has 26 conveniently located medical centers throughout metro-Atlanta: Alpharetta, Brookwood at Peachtree, Cascade, Crescent, Cumberland, Decatur, Douglasville, East Cobb, Conyers, Fayette, Forsyth, Glenlake, Gwinnett, Henry, Holly Springs, Lawrenceville, Newnan, Panola, Peachtree Center, Snellville, Southwood, Sugar-Hill Buford, TownPark, West Cobb, West Marietta, and Stonecrest.

For a listing of the providers covered under the Kaiser Permanente plan, please visit us online at www.kp.org.

How do I choose or change my primary care physician?

We ask you to choose a personal physician upon enrollment so that you and your doctor can develop a partnership and work together to make sure you get the quality care you deserve. Your personal physician will guide and coordinate any care you receive in the hospital or from specialists. And having one doctor who arranges your care and knows your medical history helps you get the right care from the right people. The relationship you build with your personal physician can help you achieve and maintain both good health and good spirits.

You may choose a physician in family medicine, general practice, adult medicine or pediatrics/adolescent medicine as a personal physician.

How do I make an appointment?

It's really easy. There is one number to call to make or cancel appointments, speak with an advice nurse, or access after-hours urgent care – regardless of which Kaiser Permanente Medical Center you use. Call the Health Line at **(404) 261-2590** locally or **(888) 865-5813** long distance.

To schedule or cancel appointments, you may call Monday through Friday from 7 a.m. to 7 p.m. The Health Line is open to speak with an advice nurse 24 hours, seven days a week. You may also schedule and cancel appointments yourself by logging into our website at www.kp.org.

What if I need to see a specialist?

As a Kaiser Permanente member, you have direct access to Audiology, Behavioral Health, Breast Care, Cardiology, Dermatology, Endocrinology, Gastroenterology, General Surgery, Infectious Disease, Nephrology, Neurology, Obstetrics/Gynecology, Oncology, Otolaryngology (ENT), Perinatology, Podiatry, Psychiatry, Pulmonology, Rheumatology, Urogynecology, Urology, Wound Care, and Pain Management.

No referral is required for specialty services available at the Kaiser Permanente medical centers. A referral is required for specialty care outside of a Kaiser Permanente medical center.

What if I need to be admitted to the hospital?

Kaiser Permanente is affiliated with some of Atlanta's most prestigious hospitals. The personal physician you choose will determine the hospital to which you will be admitted. The hospitals used for most inpatient care are: Children's Healthcare of Atlanta at Scottish Rite, Emory Eastside Medical Center, Northside Hospital, Piedmont Hospital, Rockdale Hospital, and Southern Regional Medical Center.

Get Connected.

Take a minute to register on www.kp.org and enjoy the 24-hour convenience of these secure online features:

- Order prescription refills*
- Request or cancel routine doctors' appointments*
- Get personalized plans for losing weight, managing stress, and eating healthy
- Online total health assessment as well as healthy living classes

You'll also have online access to these new, timesaving features:*

- E-mail your doctor's office
- View certain lab tests results
- Monitor your ongoing health conditions
- Review past office visit information
- And more!

It's simple. To register, visit www.kp.org/register.

*Available for members receiving care/refilling prescriptions at Kaiser Permanente medical centers

What should I do if I need Emergency Care?

If you have an emergency, call 911 or go to the nearest emergency room.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part
- serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child

If you are hospitalized, you should call (or have someone else call) the Kaiser Permanente Health Line – **(404) 261-2590** locally or **(888) 865-5813** long distance – to notify us of your hospital admission as soon as you can within 24 hours of your admission. This will allow us to consult with the physician providing your care and to coordinate further medical care.

You will pay a $150 copayment for emergency room services. (Emergency fees are waived if you're admitted.) Students attending school outside of the Kaiser Permanente service area will be covered for up to $1,000 for follow-up care associated with emergency services. You are responsible for 20% of the cost up to $1,000 for follow-up emergency care.

Do I fill out claim forms?

There are no claim forms required if care is provided, prescribed, or directed by a Kaiser Permanente physician. If there is a copayment, coinsurance, or deductible, you will be expected to pay at the time you receive the services.

If you have any questions about claims, please call a Claims Services Representative at **(404) 261-2590**.

What if I have additional questions?

Call Customer Services at **(404) 261-2590** locally or **(888) 865-5813** long distance. You can also visit our website at www.kp.org.

KAISER PERMANENTE RETIREE HMO USER GUIDE (NON-MEDICARE ELIGIBLE) 09/01/2011 - 08/31/2012 *(cont'd)*

CATEGORY	2011 - HMO PLAN DESIGN
Deductible	$300 Single / $900 Family
Out of Pocket Max	$2,000 Single / $6,000 Family
Office Visits	$15 co-pay
Specialist	$30 co-pay
Out-patient Surgery	100% covered after deductible
Maternity Out-patient	$30 co-pay 1st visit; then 100% thereafter
Pediatric Office Visit	$15 co-pay
Immunizations	$15 co-pay (well child care covered @100%)
Prescription Brand	$30 co-pay at Kaiser per 30 day supply; $40 co-pay at Rite Aid or Walgreens per 30 day supply for 1st fill only.
Prescription Generic	$10 co-pay at Kaiser per 30 day supply; $20 co-pay at Rite Aid or Walgreens per 30 day supply for 1st fill only.
Mail Order	Up to 90 days supply @ 2 times Kaiser Rx co-pay.
Inpatient Hospital Care	100% covered after deductible
Maternity In-patient	100% covered after deductible
Mental Health: Out-patient	$15 co-pay for unlimited visits
Ambulance	$150 co-pay
Emergency Room: In Plan	$150 co-pay
Emergency Room: Out Plan	$150 co-pay
Urgent Care	$30 co-pay **Two times the Medical Office visit*
Mental Health In-patient	100% covered after deductible
Substance Abuse: Out-patient	$15 co-pay for unlimited days
Substance Abuse: In-patient	Not covered
X-Rays & Lab work	Covered at 100% at KP; Subject to deductible and coinsurance in an outpatient hospital setting
Vision Eye Exam	$30 co-pay
Lenses/Frames/Contact	Discounts available
Speech Therapy	$30 co-pay; up to 20 visits per calendar year
DME Equipment	100% covered

KAISER PERMANENTE RETIREE HMO USER GUIDE (NON-MEDICARE ELIGIBLE) 09/01/2011 - 08/31/2012 *(cont'd)*

For the plan year beginning on September 1, 2011 and ending on August 31, 2012.

CITY OF ATLANTA - RETIREES	
PCP Selection	If a PCP is not chosen upon enrollment, one will be assigned based upon the medical center closest to your home.
Customer Services	(404) 261-2590 (888) 865-5813 toll free Monday - Friday 8:30 a.m. until 9:00 p.m. Saturday, Sunday 8:00 a.m. until 2:00 p.m.
Referral	Self referral to Mental Health/Chemical Dependency, Dermatology and OB/GYN Care. All other speciality care services require prior authorization from your PCP.

1. Some specific benefits have limitations.
2. Office visit copay may apply. Well-Child Visit: No Charge up to age 2.

Additional Information

- This benefit chart is a summary of the most frequently asked questions about benefits and their copayments. This is not a contract. Specific benefits, exclusions, and limitations are contained in the Group Agreement we have with your employer and the Evidence of Coverage you will receive. In the case of a conflict between this benefit chart and the Evidence of Coverage, the Evidence of Coverage will prevail. For specific questions about coverage, please ask your employer's benefits office or contact Kaiser Permanente Customer Services at **(404) 261-2590**. Benefits are subject to approval by the Georgia Department of Insurance.
- The following is a partial list of exclusions and limitations under this plan: Services that are not medically necessary; Certain exams and other services required for obtaining or maintaining employment or participation in employee/retiree programs, or required for insurance or licensing, or on court order or for parole or probation; Cosmetic services; Custodial or intermediate care; Services that an employer is required by law to provide; Experimental or investigational services; Eye surgery, including laser surgery, to correct refractive defects; Services that a government agency is required by law to provide; Services for conditions arising from military service; Services related to the treatment of morbid obesity (except certain health education programs are covered); Routine foot care; Sexual reassignment services; Non-human or artificial organs or their implantation; Reversal of voluntary infertility; Transportation and lodging expenses; Conditions covered by workers' compensation or under employer liability law; Services not generally and customarily available in our service area.
- In order for Services to be covered, a Plan Physician must determine that the Services are medically necessary to prevent, diagnose, or treat your medical condition. With the exception of emergency services, all covered Services must be provided, prescribed, authorized, or directed by a Plan Physician. You must receive the Services at a Plan Facility inside our Service Area, except where specifically noted to the contrary in the Evidence of Coverage. Certain covered services require pre-authorization by Medical Group.
- We use a formulary, which is a listing of medications that our physicians and pharmacists consider to be the most safe, useful and cost-effective ones available. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. Coverage for prescription drugs is limited to those drugs that are included on the Kaiser Permanente formulary. For a copy of the formulary brochure or for more information about the exception process, contact Customer Services at **(404) 261-2590**.
- For details on the benefit and claims review and adjudication procedures, please refer to your Evidence of Coverage.
- Kaiser Permanente maintains policies regarding the confidentiality, protection, and disclosure of personal health and member identifiable information, including policies related to access to medical records. If you have questions about our policies and procedures to maintain the confidentiality of personal information or would like a more comprehensive notice describing how Kaiser Permanente collects and uses personal information, please call Customer Services at **(404) 261-2590**.
- If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you or those of your eligible dependents who later have that coverage terminated for a reason other than fraud, misrepresentation or non-payment, may at that time be able to enroll in this health plan, provided that you request enrollment within 30 days after the other coverage ends. We may require sufficient proof of that other coverage and the reason for its termination. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

This plan summary is intended to only highlight some of the principal provisions of the plan. Please refer to the Group Agreement or Evidence of Coverage for further details of the plan or for specific limitations and exclusions.

KAISER PERMANENTE CONSUMER CHOICE OPTION

Effective January 1, 2000, Georgia law required insurers to offer a "Consumer Choice" option to members enrolling in a plan. This option allows members to receive services from a non-network provider (physician, hospital or other provider) while still being covered at an in-network level.

Although you may "nominate" any non-network provider, the nominated doctor or hospital must first agree to the following in order for your services to be covered at the in-network rate:

1. Accept the insurer's reimbursement as payment in full (in addition to the members' usual copayment, deductibles and/or coinsurance).
2. Comply with the insurer's utilization management programs.

After you select the out-of-network provider, you must complete a Provider Nomination Form and receive notification from the insurer that the nomination has been accepted before out-of-network providers can be reimbursed at in-network benefit levels. For any nominations to be approved, the provider must sign the form agreeing to the insurer's terms and conditions before that provider's services will be covered at in-network levels. The provider makes the decision regarding whether he or she will participate in the Consumer Choice Option plan.

The law does not obligate a provider to accept an insurer's terms and conditions or its reimbursement rates. If a provider elects not to sign the Consumer Choice Option Provider Nomination Form, he or she is under no obligation to do so.

If you are seeking services from a specific provider, we recommend that you check with that provider BEFORE completing the Consumer Choice Option application and making a final plan election.

The law allows insurers to increase the monthly premium rate for retirees who elect this offering. **The amount of the monthly premium increase is 17.5% over the total Kaiser HMO rates for Consumer Choice Option HMO.** Because this amount is billed to the City of Atlanta, your deductions by the City will be higher than the deductions would be if you did not choose this option. You are responsible for the applicable 17.5% increase for HMO as well as the usual retiree deduction. You should check with the DHR Insurance Division at **(404) 330-6036** to determine the exact amount to be deducted before you elect a Consumer Choice Option plan.

Selecting the Consumer Choice Option is just like selecting any other benefit option. You must do so either during annual enrollment, when newly hired or when the City's eligibility rules allow you to do so.

You must contact the DHR Insurance Division (404) 330-6036 if you wish to apply for the Consumer Choice Option on your HMO plan.

Medicare Plans

IMPORTANT NOTICE FROM THE CITY OF ATLANTA ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Atlanta and new prescription drug coverage first available January 1, 2006 for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. **Starting January 1, 2006, new Medicare prescription drug coverages were made available to everyone with Medicare.**
2. **The City of Atlanta has determined that the prescription drug coverage offered by BlueChoice and Kaiser are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay for the period September 1, 2011 - August 31, 2012.**
3. **Read this notice carefully – it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.**

Anyone with Medicare can enroll in a Medicare prescription drug plan from November 15 through December 31, each year with no penalty. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later.

IF YOU ENROLL IN ANY ADDITIONAL MEDICARE PRESCRIPTION DRUG PLAN, YOUR COVERAGE WITH THE CITY OF ATLANTA WILL BE TERMINATED. FOR FURTHER INFORMATION, CONTACT 404-330-6036.

If you drop your coverage with the City of Atlanta and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering a Medicare prescription drug program in your area.

In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you may still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan. Thus the importance of really looking at a plan before you give up coverage through The City of Atlanta.

You should also know that if you drop or lose your coverage with the City of Atlanta and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that creditable coverage. For example, if you go nineteen months without creditable coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay an extra penalty if you later decide to enroll in Medicare coverage.

IMPORTANT NOTICE FROM THE CITY OF ATLANTA ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE *(cont'd)*

For more information about this notice or your current prescription drug coverage…

Contact the Insurance Division for more information at **(404) 330-6036.**

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage can be found in the following places:

- visit www.medicare.gov for personalized help;
- call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number); or
- call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15. 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

PLEASE NOTE: If you sign up for any **Medicare Advantage Plan** (other than Senior Advantage offered by Kaiser or BCBS-Anthem MedicarePreferred (PPO) that may be offered to you directly by various vendors, **YOUR COVERAGE THROUGH THE CITY OF ATLANTA WILL BE TERMINATED.** If you have any questions about this, please call the DHR – Insurance Division at **(404) 330-6036** before signing up for another plan.

MEDICARE MEDICAL PLAN COMPARISON

Plan Provisions	BCBS-Anthem Medicare Preferred (PPO) In-Network / Out of Network	Kaiser Sr. Advantage
Lifetime Maximum	Unlimited	Unlimited
Deductible		
☐ Individual	$0	N/A
☐ Family	$0	N/A
Coinsurance		
☐ Individual	$3350	$3000
☐ Family	$0	$9000
Preventive Care		
☐ Immunizations	$0 copay	$10 Copay / (well-child care covered @ 100% up to age 2)
☐ Pap Smear/Mammography/Prostate Screening	$0 copay	$30 copay
☐ Routine Physicals	$0 copay	$10 copay
Office Visits		
☐ Physical Therapy (Occupational)	$0 copay	$30 co-pay; unlimited visits
☐ Primary Care	$15 copay	$10 copay
☐ Urgent Care	$15 copay	$20 copay
☐ Specialists	$25 copay	$30 copay
Emergency Services		
☐ Hospital (Waived if admitted)	$50 copay	$50 copay
Inpatient Hospital	$250 copay per admit/ 3 copay max yr	$200 copay per admit
Outpatient Hospital Services		
☐ Hospital Charges	$100 copay	$100 copay
☐ Physician Services	No Charge	No Charge
Mental Health/Substance Abuse		
☐ Inpatient Mental Health Treatment	Plan pays @ 100% (unlimited visits)	$30 copay (unlimited days)
☐ Outpatient Mental Health Treatment	Plan pays @ 100% (unlimited visits)	$30 copay (unlimited visits)
Ambulance Service	$100 copay	$100 copay
DME Equipment	$0 copay	covered at 100%
Skilled Nursing Facility	No Charge	No Charge
Home Health Care	No Charge	120 visits max
Hospice	No Charge	No Charge
Prescription Drugs		
☐ Generic	$10	$10
☐ Brand	$20	$30
☐ Brand Non-Preferred	$40	N/A
☐ Mail Order	2x Retail Copay	90 days supply @ 2 times Kaiser RX Copay
Vision		
☐ Eye Exam once every 12 months	$15 copay ($50 max)	$30 copay
☐ Frames and Lenses once every 24 months	Discount Plan	$100 Credit (Frames, Contacts)
Service Area	Any provider who participated in the Original Medicare and agrees to the terms and conditions of BCBS – Antehm Medicare Preferred (PPO).	Barrow, Bartow, Butts, Cherokee, Clayton, Cobb, Coweta, Dekalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Newton, Paulding, Rockdale, Spalding, and Walton Counties

BCBS – ANTHEM MEDICARE PREFERRED (PPO) USER GUIDE 09/01/2011 - 08/31/2012

Introducing Anthem Medicare Preferred (PPO)

All play and no work makes for a great retirement. Worthwhile health care coverage is supposed to work for you, not the other way around. That's where the value of Anthem Medicare Preferred (PPO) comes in. As a plan member, you get access to all of the benefits that are available to you under standard Medicare coverage.

But here are just a few differences that set Anthem Medicare Preferred (PPO) plan coverage apart:

- Plan benefits include set fees for most services like health care professional's office visits, emergency room visits and inpatient hospital stays so you typically know upfront what you can expect to pay for medical care you receive.
- Receiving your coverage through a Local PPO plan instead of through traditional Medicare means that we take care of the paperwork for you.
- Plan provides all the benefits covered by original Medicare. In addition, supplemental benefits (e.g. dental, vision) may be provided as part of the same product benefits.
- The drug coverage that is included in your plan benefits is better than Original Medicare coverage.

But wait, there's more.

Anthem Medicare Preferred (PPO)

Anthem Medicare Preferred (PPO) plans do not simply mirror Medicare coverage. They also include access to important resources that can support you when you've got health care decisions to make. And even some extras thrown in like discounts. It's all part of an integrated approach we've developed called Custom Care Connection. What does that mean? Simply put, it's our comprehensive approach that not only helps pay for your medical bills, but also gives you the customized tools and support you need to make the most of your coverage.

Custom Care Connection includes:

- Preventive care services that can help you feel healthier or help treat problems at their earliest stages
- Condition management for members dealing with chronic conditions such as diabetes, COPD, kidney disease or certain heart ailments
- Care management for members dealing with multiple conditions or acute health issues
- A dedicated nurse line available to you 24 hours a day, 7 days a week

Enrolling in Anthem Medicare Preferred (PPO) plan coverage is easy because there are no physicals required upfront and there are no limitations to your coverage if you are already dealing with pre-existing medical conditions.

Your plan coverage will include:

- Health care professional office visits for wellness as well as for sick visits
- Inpatient hospital stays
- Outpatient hospital services
- Emergency room or urgent care services
- Ambulance services
- Durable medical equipment
- Diagnostic testing including X-rays and laboratory services
- Short-term and maintenance prescription medications

See the value for yourself

Anthem Medicare Preferred (PPO) coverage gives you:

- Full coverage that can begin as soon as your effective date
- Benefits with many setfees, taking the guess-workout of what you'll pay

- Freedom to escape the paper trails that typically come with traditional Medicare coverage
- Devoted customer service staff solely available for our retiree members
- Drug coverage that's better than standardMedicare Part D benefits
- Freedom to "move aboutthe country" with a travel benefit that saves you money

Selecting a doctor

With your Anthem Medicare Preferred (PPO) plan, you can see any doctor you want. You have the option of using the doctors in our network who have agreed to participate with us. Or you can use a non-network provider.

Working with network providers has many advantages. These doctors and hospitals will:

- File claims for you so there's no paperwork for you to handle
- Work with accepted fees for specific services, so that means less money out of your pocket

Seeing a Specialist

Your plan allows you to seek specialist visits without first receiving a referral from your primary care physician. See your Provider Directory and our website for provider information about network specialists. For certain services, your network physician will need to get prior approval from us. Please refer to your Benefit Chart for the services which require prior authorization.

Preventive services to keep you at your healthiest

Research shows that being in tune with your healthcan help you prevent problems before they occur or at least minimize their progression. That's why your Anthem Medicare Preferred (PPO) plan includes layers of support to give you the tools and resources you need for the best possible health outcomes. Preventive services are available at no additional cost or deductible to pay.

A team of support

Questions about your coverage? That's no problem for the team of dedicated customer service reps who are wholly focused on your coverage and benefit needs and are trained and ready to help you with any coverage and benefit concern you may have.

Getting medical care

As an Anthem Medicare Preferred (PPO) member, you can seek care from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. Here are other important things to know about using out-ofnetwork providers:

- Anthem Medicare Preferred (PPO) members can see any doctor or hospital that participates with this plan and receive the highest level of benefits. So no matter where life takes you, your health coverage goes with you. With our Anthem Medicare Preferred (PPO) plans, through the Blue Medicare Advantage PPO Network Sharing Program, you have access to health care services while traveling or living anywhere in another Blue plan's service area. We help make it easy to get the care you need. Blue Medicare Advantage PPO Network Sharing is a national program that enables members of one Blue company to obtain healthcare services while traveling or living in another Blue company's service area. The program links participating healthcare providers with the independent Blue companies across the country, through a single electronic network for claims processing and reimbursement
- Our CMS defined geographic service area includes all 50 states, Puerto Rico and Washington DC. Although most Anthem Medicare Preferred (PPO) members will have access to contracting providers, you may need to obtain services from out-of-network providers.

- If you are in an area without network providers available for you to see, you can go to an out-of-network provider but you will only be responsible to pay the in-network amounts.
- You can get your care from an out-of-network provider, however, that provider must participate in Medicare. Anthem Medicare Preferred (PPO) cannot pay a provider who has decided not to participate in Medicare. If you receive care from a provider that does not participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they have not opted out of Medicare. You, or someone acting on your behalf, can also access the list of Medicare participating providers at: http://www.medicare.gov/physician/search/chooseprovider.asp

Determining if you are in an area with access to PPO participating providers: To determine if you are in an area with access to a PPO participating provider, please refer to your provider directory for information on participating network areas or call the member services number on the back of your identification card.

Finding a Blue Medicare Advantage PPO provider

To help you locate a participating provider:

1. call your plan's member service phone number on the back of your identification card during regular business hours,

2. all 1-800-810-BLUE (2583) to find a Blue Medicare Advantage PPO provider, or

3. Visit the "Doctor & Hospital Finder" at www.bcbsga.com to find a Blue Medicare Advantage PPO provider.

Finding a provider when no PPO participating provider network is available

If you are in an area without access to Blue Medicare Advantage PPO network providers,

you can use out-of-network providers and still receive in-network benefits.

1. If you are currently using providers that participate with Medicare, you should first inform your current providers that

- You are enrolled under a new plan
- Although the new plan is a PPO, you can continue to be seen by them if they agree
- You, the member, will receive in-network benefits

2. If the provider elects to not provide services, you can self refer to another provider that participates in Medicare.

3. If you are unable to find a provider, please contact member services who will:

- respond with at least one provider of the requested provider type(s) within

reasonable travel distance.

- respond within 72 hours for standard requests for a provider
- respond on the same day for urgent care services (medical services to be furnished within 12 hours in order to avoid the likely onset of an emergency medical condition).

Identification cards

Whether you live in an area with or without a participating Blue Medicare Advantage PPO network, you will receive a new identification card that is unique to the Anthem Medicare Preferred (PPO) plan.

Excellent customer service

Anthem Medicare Preferred (PPO) members receive the same outstanding customer service afforded to Blue Cross Blue Shield of Georgia members. Members can receive service either by calling their Customer Service phone number or submitting inquiries through the Anthem Medicare Preferred (PPO) website. Many plans also have walk-in customer service centers located in major cities.

Valuable extras for added support*

*Valuable extras for added support. Please note: the valued added products and services described on this page are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Blue Cross Blue Shield of Georgia grievance process.

24-hour Nurse Information Line and HealthLine Audiotape Library

Health concerns don't always occur during times when your health care professional's office is open. The 24-hour Nurse Information Line is a convenient alternative that you can call any time of the day or night, 365 days a year. Helpful and supportive nurses will guide you on over-the-counter remedies or provide educational information to allow you to make the determination if and when you need to seek care from a health care professional. Just want to get some information on a particular healthrelated topic, but don't want to speak to a nurse? You can do that too by calling the HealthLine Audiotape Library with access to prerecorded content on hundreds of health-related topics.

The SilverSneakers® Fitness Program

As an Anthem Medicare Preferred (PPO) member, it's easy and affordable to stay fit, have fun and make friends. Your SilverSneakers® Fitness Program membership is available to you as part of your Medicare Advantage plan. You'll have access to more than 10,000 locations across the country, to inspire workouts close to home and on your next vacation. Participating SilverSneakers locations offer amenities such as:

- fitness equipment, treadmills and free weights
- SilverSneakers fitness classes, including YogaStretch and SilverSplash, designed specifically for older adults and taught by certified instructors
- a designated on-site staff member to help you along the way
- health education seminars and fun social events SilverSneakers Steps is a personalized fitness program that fits the lifestyle of members who live 15 miles or more from a SilverSneakers fitness location. After registering as a Steps member on www.silversneakers.com, you are able to set your goals and track your accomplishments to create a personalized path to wellness.

You'll receive your free Steps kit, which has the tools you need to get fit, including resistance bands, an exercise DVD and how-to materials.

Vendors and offers are subject to change without prior notice. Blue Cross Blue Shield of Georgia does not endorse and is not responsible for the products, services or information provided by the Special Offers vendors. Arrangements and discounts were negotiated between each vendor and Blue Cross Blue Shield of Georgia for the benefit of our members.

Emergency care/urgent care

There are few things more frightening than being faced with a medical emergency. By all means, if you ever experience a life threatening illness or i jury, call 911 or go to the nearest hospital. Your care should be covered no matter where you are.

Sometimes it's hard to know if your illness or injury is truly an emergency. Often you may be experiencing symptoms that need prompt attention, but not the use of an emergency room. Members can call the Nurse Information line for guidance. It is open 24 hours a day, 7 days a week. This Nurse Information line phone number is located on the back of your ID card. In addition, use the guidelines below as a general checklist to keep in mind before visiting an emergency room. Your care will be covered at either an emergency room or urgent care center as long as your illness or condition generally meets the definition for what is considered an emergency or urgent situation.

But, your health care professional's office or urgent care center can normally treat any minor illness or injury and is a more appropriate place to get treatment so that emergency room services can remain available to those who truly need that level of care.

Emergency care versus urgent care. What's the difference?

Emergency care is usually defined as when a person reasonably believes that there is an immediate threat to health. Examples include:

- convulsions / seizures
- respiratory arrest
- unconsciousness
- poisoning
- broken bone
- shock

Urgent care situations are typically those in which the illness or injury is less severe, but you still need prompt attention. Examples of urgently needed care include:

- abdominal pain
- bad sunburns or other minor burns
- earache
- persistent nausea / vomiting
- significant flu or sore throat
- significant sprain

CONTACT INFORMATION

Questions or concerns? Keep these phone numbers as a handy future reference.

Blue Cross Blue Shield of Georgia First Impressions Welcome Line

1-877-411-1647 TTY: 1-877-247-1657

Monday - Friday 8 a.m. to 8 p.m.

Please note: The First Impressions phone number listed above is available to you for any initial questions you may have prior to your effective date.

Please note that once your coverage is activated, future questions or concerns should be raised to the customer service phone number listed to the right.

Blue Cross Blue Shield of Georgia Customer Service

1-877-411-1640 TTY: 1-877-247-1657

Seven days a week 8 a.m. to 8 p.m.

P.O. Box 110

Fond du Lac, Wisconsin 54936

www.bcbsga.com

Medicare

1-800-MEDICARE (1-800-633-4227)

TTY/TDD 1-877-486-2048

Seven days a week, 24 hours a day

www.medicare.gov

Finding a Blue Medicare Advantage PPO provider

To help you locate a participating provider:

1. call your plan's member service phone number on the back of your identification

card during regular business hours,

2. call 1-800-810-BLUE to find a Blue Medicare Advantage PPO provider, or

3. Visit the "Doctor & Hospital Finder" at www.bcbsga.com to find a Blue

Medicare Advantage PPO provider.

BCBS – ANTHEM MEDICARE PREFERRED (PPO) USER GUIDE 09/01/2011 - 08/31/2012 *(cont'd)*

Exclusions and Limitations

As with any health plan, specific exclusions and limitations are assigned to the plan benefits being offered to you. Full disclosure of these exclusions and limitations will be provided in the Annual Notice of Change and Evidence of Coverage brochure you'll be receiving from BCBSGA.

Enrolling in BCBS – Anthem Preferred Medicare (PPO) Coverage

Enrolling in BCBS – Anthem Preferred Medicare (PPO) plan coverage is easy because there are no physicals required up front and there are no limitations to your coverage if you are already dealing with pre-existing medical conditions.

An Important Note About Part D Drug Coverage

The Part D prescription drug coverage being offered to you is only available to you if you are also electing the Medicare Advantage health plan coverage. You may only be enrolled in one Part D plan. If you're currently enrolled under another Part D plan, you will need to disenroll from that plan.

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users should call **1-877-486-2048**, 24 hours a day/7days a week;
- the Social Security Administration at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday thru Friday. TTY/TDD users should call, **1-800-325-0778**; or your state Medicaid office.

Questions Before You Enroll? Get to Know the First Impressions Welcome Center

The First Impressions Welcome Center is a phone line, staffed by helpful Blue Cross/Blue Shield of Georgia representatives that will take the time to answer your questions and talk with you about the SmartValue Plan.

First Impressions Welcome Center
(866) 657-4970
(800) 425-5705 (for TTY/TDD users)
Monday through Friday
8 a.m. to 9 p.m. Eastern Time

- If you need this document in an alternate format, please contact the First Impressions Welcome Center.

PLEASE NOTE: If you sign up for any **Medicare Advantage Plan** (other than Senior Advantage offered by Kaiser or BCBS – Anthem Mediacre Preferred (PPO) that may be offered to you directly by various vendors, **YOUR COVERAGE THROUGH THE CITY OF ATLANTA WILL BE TERMINATED.** If you have any questions about this, please call the DHR – Insurance Division at **(404) 330-6036** before signing up for another plan.

KAISER PERMANENTE SENIOR ADVANTAGE HMO USER GUIDE (MEDICARE ELIGIBLE) 09/01/2011 - 08/31/2012

When joining Kaiser Permanente Senior Advantage, you must complete a separate application. When/if you terminate your Kaiser Senior Advantage, you must complete a Medicare disenrollment form.

Complete. Simple. Affordable. Now That's a Senior Advantage

Complete.

You'll have peace of mind knowing you're covered for:

- *Medical* – Includes doctor visits, vision services, physical exams, screenings and more
- *Hospital* – An unlimited number of days each hospital stay costs you only $200
- *Prescriptions* – Coverage for all brand and generic drugs listed on our formulary

Simple.

You'll enjoy a plan that's simple to understand and simple to use.

- One low monthly premium pays for all your coverage
- No claims to file

And so much more!

When you join Kaiser Permanente Senior Advantage, you'll get high quality, personalized care from our award-winning medical group. You'll also love the timesaving convenience of our medical centers. And, you'll have the tools you need to help keep you health – like access to 24-hour health coaches or nurse advice, discounts on health-related services, online self-help tools, health classes and more.

How do I choose or change my primary care physician?

We ask you to choose a personal physician upon enrollment so that you and your doctor can develop a partnership and work together to make sure you get the quality care you deserve. Your personal physician will guide and coordinate any care you receive in the hospital or from specialists. And having one doctor who arranges your care and knows your medical history helps you get the right care from the right people.

The relationship you build with your personal physician can help you achieve and maintain both good health and good spirits.

You may choose a physician in family medicine, general practice, adult medicine or pediatrics/adolescent medicine as a personal physician. (Refer to the *Kaiser Permanente Senior Advantage HMO Physician Directory* in your enrollment packet for specifics or www.kp.org.)

Simply call our Customer Service Department at **(404) 261-2590** locally or **(888) 865-5813** long distance.

How do I make an appointment?

It's really easy. There is one number to call to make or cancel appointments, speak with an advice nurse, or access after-hours urgent care – regardless of which Kaiser Permanente Medical Center you use. Call the Health Line at **(404) 261-2590** locally or **(888) 865-5813** long distance. **(TTY: 800-255-0056)**.

To schedule or cancel appointments, you may call Monday through Friday from 7 a.m. to 7 p.m. The Health Line is open to speak with an advice nurse 24 hours a day, seven days a week. You may schedule or cancel appointments by logging on to kp.org

What if I need to see a specialist?

When you select a personal physician, keep in mind that your choice will determine which specialists are available to you. Your personal physician has an established relationship with a specific group of specialty care doctors with whom he or she works with on a regular basis. By referring only to a certain group of specialists, your physician is better able to coordinate and oversee your care. You must get a referral from your personal physician in order to see a specialist. If you change your personal physician, the specialists available to you may also change.

Referral specialists are listed in your Kaiser Permanente Senior Advantage HMO Physician Directory.

As a Kaiser Permanente member, you have direct access to Audiology, Behavioral Health, Breast Care, Cardiology, Dermatology, Endocrinology, Gastroenterology, General Surgery, Infectious Disease,

Neurology, Obstetrics/Gynecology, Oncology, Otolaryngology (ENT), Podiatry, Psychiatry, Pulmonology, Rheumatology, Urology and Wound Care.

No referral is required for specialty services available at the Kaiser Permanente medical centers. A referral is required for specialty care outside of a Kaiser Permanente medical center.

What if I need to be admitted to the hospital?

Kaiser Permanente is affiliated with some of Atlanta's most prestigious hospitals. The personal physician you choose will determine the hospital to which you will be admitted. The hospitals used for most inpatient care are: Children's Healthcare of Atlanta at Scottish Rite, Emory Eastside Medical Center, Northside Hospital and Piedmont Hospital.

Get Connected.

Take a minute to register on www.kp.org and enjoy the 24-hour convenience of these secure online features:

- Order prescription refills*
- Request or cancel routine doctors' appointments*
- Get personalized plans for losing weight, managing stress, and eating healthy
- Online total health assessment as well as healthy living classes

You'll also have online access to these new, timesaving features:*

- E-mail your doctor's office
- View certain lab tests results
- Monitor your ongoing health conditions
- Review past office visit information
- And more!

It's simple. To register, visit www.kp.org/register.

*Available for members receiving care/refilling prescriptions at Kaiser Permanente medical centers

What should I do if I need emergency care?

If you have an emergency, call 911 or go to the nearest emergency room.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

If you are hospitalized, you should call (or have someone else call) the Kaiser Permanente Health Line – **(404) 261-2590** locally or **(888) 865-5813** long distance – to notify us of your hospital admission as soon as you can within 24 hours of your admission. **(TTY: 800-255-0056)**. This will allow us to consult with the physician providing your care and to coordinate further medical care.

You will pay a $50 copayment for emergency room services. (Emergency fees are waived if you're admitted.) Students attending school outside of the Kaiser Permanente service area will be covered for up to $1,000 for follow-up care associated with emergency services. You are responsible for 20% of the cost up to $1,000 for follow-up emergency care.

Do I fill out claim forms?

There are no claim forms required if care is provided, prescribed, or directed by a Kaiser Permanente physician. If there is a copayment, coinsurance, or deductible, you will be expected to pay at the time you receive the services.

If you have any questions about claims, please call a Claims Services Representative at **(404) 261-2590**. **(TTY: 800-255-0056)**.

What if I have additional questions?

Call Senior Advantage Customer Services Department from 8:30 a.m. to 5 p.m., Monday through Friday, at **(404) 233-3700** or **(800) 232-4404**, or **(800) 255-0056** (TTY for the hearing and speech impaired). You can also visit our website at www.kp.org.

Note: Retirees and/or their spouses covered by Parts A & B of Medicare who enroll with Kaiser Permanente are only eligible for Senior Advantage. Other family members may enroll in the HMO plan.

KAISER PERMANENTE SENIOR ADVANTAGE
09/01/2011 - 08/31/2012

CATEGORY	09/01/2011 - 08/31/2012 – HMO PLAN DESIGN
Deductible	Not applicable
Office Visits	$10 co-pay
Specialist	$30 co-pay
Out-patient Surgery; facility; visits	$100 co-pay, (inclusive of High-tech Radiology and Colonoscopy)
Maternity Out-patient	$30 co-pay 1st visit; then 100% thereafter
Pediatric Office Visit	$10 co-pay
Immunizations	$10 co-pay, (well child care covered @100% up to age 2)
Prescription Brand	$30 co-pay at Kaiser per 30 day supply; $36 co-pay at Rite Aid or Walgreens per 30 day supply
Prescription Generic	$10 co-pay at Kaiser per 30 day supply; $16 co-pay at Rite Aid or Walgreens per 30 day supply
Mail Order	90 days supply @ 2 times Kaiser Rx copay. Mail order available only through Kaiser Permanente pharmacies
Inpatient Hospital Care	$200 co-pay per admission
Maternity In-patient	100% covered after $200 co-pay
Mental Health: Out-patient	$10 co-pay; unlimited visits
Ambulance	$100 co-pay
Emergency Room: In Plan	$100 co-pay
Emergency Room Out Plan	$100 co-pay
Urgent Care	$20 co-pay
Mental Health In-patient	$200 co-pay; unlimited days
Substance Abuse: Out-patient	$10 co-pay; unlimited visits
Substance Abuse: In-patient	Not covered
X-Rays & Lab work	100% covered if performed in a physicians office; $100 copay if performed in an out-patient hospital setting
Vision Eye Exam	$30 co-pay
Frames/Contact Lenses	Discounts available
Infertility	$30 co-pay for diagnosis; 50% for treatment.
Physical/Occupational Therapy (combined benefit)	$30 co-pay; limited to 20 visits
Speech Therapy	$30 co-pay; limited to 20 visits
DME Equipment	100% covered

KAISER PERMANENTE SENIOR ADVANTAGE HMO USER GUIDE (MEDICARE ELIGIBLE) 09/01/2011 - 08/31/2012 *(cont'd)*

For the plan year beginning on September 1, 2011 and ending on August 31, 2012.

CITY OF ATLANTA – SENIOR ADVANTAGE

Additional Information

- This benefit chart is a summary of the most frequently asked about benefits and their copayments. This is not a contract. Specific benefits, exclusions, and limitations are contained in the Group Agreement we have with your employer and the Evidence of Coverage you will receive. In the case of a conflict between this benefit chart and the Evidence of Coverage, the Evidence of Coverage will prevail. For specific questions about coverage, please ask your employer's benefits office or contact Kaiser Permanente Customer Services at **(404) 261-2590**. Benefits are subject to approval by the Georgia Department of Insurance.
- The following is a partial list of exclusions and limitations under this plan: Services that are not medically necessary; Certain exams and other services required for obtaining or maintaining employment or participation in employee/retiree programs, or required for insurance or licensing, or on court order or for parole or probation; Cosmetic services; Custodial or intermediate care; Services that an employer is required by law to provide; Experimental or investigational services; Eye surgery, including laser surgery, to correct refractive defects; Services that a government agency is required by law to provide; Services for conditions arising from military service; Services related to the treatment of morbid obesity (except certain health education programs are covered); Routine foot care; Sexual reassignment services; Non-human or artificial organs or their implantation; Reversal of voluntary infertility; Transportation and lodging expenses; Conditions covered by workers' compensation or under employer liability law; Services not generally and customarily available in our service area.
- In order for Services to be covered, a Plan Physician must determine that the Services are medically necessary to prevent, diagnose, or treat your medical condition. With the exception of emergency services, all covered Services must be provided, prescribed, authorized, or directed by a Plan Physician. You must receive the Services at a Plan Facility inside our Service Area, except where specifically noted to the contrary in the Evidence of Coverage. Certain covered services require pre-authorization by Medical Group.
- We use a formulary, which is a listing of medications that our physicians and pharmacists consider to be the most safe, useful and cost-effective ones available. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. Coverage for prescription drugs is limited to those drugs that are included on the Kaiser Permanente formulary. For a copy of the formulary brochure or for more information about the exception process, contact Customer Services at **(404) 261-2590.**
- For details on the benefit and claims review and adjudication procedures, please refer to your Evidence of Coverage.
- Kaiser Permanente maintains policies regarding the confidentiality, protection, and disclosure of personal health and member identifiable information, including policies related to access to medical records. If you have questions about our policies and procedures to maintain the confidentiality of personal information or would like a more comprehensive notice describing how Kaiser Permanente collects and uses personal information, please call Customer Services at **(404) 261-2590.**

This plan summary is intended to only highlight some of the principal provisions of the plan. Please refer to the Group Agreement or Evidence of Coverage for further details of the plan or for specific limitations and exclusions.

CIGNA DENTAL PPO PLAN
SUMMARY OF BENEFITS
09/01/2011 - 08/31/2012

Description of Benefits

The City offers the choice of two CIGNA Dental PPO plans (High or Low Option) for you and your eligible dependents. These comprehensive plans are administered by CIGNA Dental.* Most dental services, including preventive care, are covered. The annual dollar maximum for both the High and Low Options is $2,000.

Who Can Provide Services

The CIGNA Dental PPO plan is a preferred provider program. Members can seek care in- or out-of network. Participating CIGNA Dental network dentists have agreed to charge reduced fees for covered services; out-of-network dentists provide services at their usual fees. When you use an out-of-network dentist, you may be billed for the difference between the payment the dentist receives from CIGNA and his/her usual fees.

Proof of Coverage

After enrollment, you will receive a CIGNA Dental PPO ID card. However, the ID card is not required to access care.

Claims

Most network dentists will file claims on your behalf; out-of-network dentists may ask you to file the claim. CIGNA Dental will determine benefits, and payment will be made to the dentist or to you based on what is indicated on the claim form. Generally, you or your dentist should receive reimbursement in about three weeks.

How to Obtain Assistance

Help is only a phone call away! If you have questions about the dental plans, want to know the status of a claim, or need to know if specific services are covered, you can contact CIGNA Dental Member Service toll-free at **1-800-CIGNA24 (1-800-244-6224)**. You can also access personalized dental plan information when you register at ***www.myCIGNA.com***. Through myCIGNA.com, you can:

- Review your dental benefit plan information, including individual and family maximums and deductibles
- Find network dentists through the on-line provider directory
- Check on the status of a claim
- Access dental health news and information from trusted sources
- Print Dental ID cards

How to Appeal Claims

If you disagree with the processing of your claim, you have the right to ask for a review of the claim. Please refer to the "Right to Appeal" section of your benefit booklet for details.

Orthodontics in Progress

"Orthodontics in progress" refers to orthodontic care in progress at the time your dental coverage becomes effective. If your dependent is in the midst of orthodontic treatment when you join the plan, you may be eligible for some contribution.

Your CIGNA Dental PPO plan provides an orthodontic benefit; it covers orthodontics in progress, subject to your plan limitations. The orthodontics in progress benefit is calculated based on the coinsurance level for orthodontic treatment and the number of months of treatment remaining after your effective date. Benefit amounts are payable up to the lifetime dollar maximums or until the treatment is completed, which ever comes first.

Your CIGNA Dental PPO plan also covers orthodontics for new members who are in treatment prior to enrollment. Treatment will become effective the date the retiree becomes effective. The original treatment must be submitted by the provider, which should include the total months of treatment, total fee (including retention) and the banding date. The contracted rate will be paid for the remaining months of treatment until the lifetime maximum has been met or until the treatment is completed, whichever comes first.

The patient balance due on the EOB will be incorrect because CIGNA will only be responsible to pay up to the PPO contracted amount for the remaining months of treatment. However, the patient will be liable for the provider's original case fee because that was the original financial agreement between the patient and provider.

** CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries. The CIGNA Dental PPO is underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc., and certain of its operating subsidiaries.*

CIGNA DENTAL PPO PLAN
SUMMARY OF BENEFITS
09/01/2011 - 08/31/2012 *(cont'd)*

This is a summary of benefits for your PPO plan. All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in- and out-of-network.

BENEFITS	CIGNA DENTAL HIGH PPO		CIGNA DENTAL LOW PPO	
	IN-NETWORK	OUT -OF-NETWORK	IN-NETWORK	OUT -OF-NETWORK
Calendar Year Maximum (Class I, II, and III Expenses)	$2,000	$2,000	$2,000	$2,000
Calendar Year Deductible Per Individual Per Family	$50 $150	$50 $150	$50 $150	$50 $150
Class I Expenses – Preventive & Diagnostic Care Oral Exams Cleanings (1 per 6-month consecutive period) Bitewing X-rays Fluoride Application Sealants Space Maintainers *(limited to non-orthodontic treatment)* Full Mouth X-rays Panoramic X-rays	100% No deductible	100% No deductible Subject to reasonable and customary allowances.	100% No deductible	100% No deductible Subject to reasonable and customary allowances.
Class II Expenses - Basic Restorative Care Emergency Care to Relieve Pain Fillings Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Major Periodontics ** Minor Periodontics ** Root Canal/Therapy	80%, After Deductible	80%, After Deductible Subject to reasonable and customary allowances.	80%, After Deductible	80%, After Deductible Subject to reasonable and customary allowances.
Class III Expenses - Major Restorative Care Anesthetics Relines, Rebases, and Adjustments Repairs - Bridges, Crowns and Inlays Repairs - Dentures Crowns Dentures Bridges Histopathologic Exams TMJ coverage (with separate $1000 lifetime max)	50%, After Deductible	50%, After Deductible Subject to reasonable and customary allowances.	50%, After Deductible	50%, After Deductible Subject to reasonable and customary allowances.
Class IV Expenses - Orthodontia Coverage for Eligible Children and Adults Lifetime Maximum	50% No Separate Deductible $1,500	50% No Separate Deductible $1,500	Not Covered	Not Covered
Missing Tooth Provision	Teeth missing prior to coverage under the CIGNA Dental plan are not covered.		Teeth missing prior to coverage under the CIGNA Dental plan are not covered.	
Pretreatment Review	Available on a voluntary basis when extensive work in excess of $500 is proposed.		Available on a voluntary basis when extensive work in excess of $500 is proposed.	
Out-of-Network Reimbursement	80th Percentile of Reasonable and Customary Allowances		80th Percentile of Reasonable and Customary Allowances	
Student Age	26		26	

* *CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries. The CIGNA Dental PPO is underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc., and certain of its operating subsidiaries.*

***** Perio coverage has a separate $1,000 lifetime maximum.***

CIGNA DENTAL PPO PLAN MEMBER GUIDE 09/01/2011 - 08/31/2012 *(cont'd)*

CIGNA Dental PPO/Indemnity Exclusions and Limitations

Procedure	Exclusions & Limitations
Late Entrants Limit	No coverage except for Class I (as defined in these plans) for 12 months
Exams	1 per 6-month consecutive period
Prophylaxis (Cleanings)	1 routine prophy or perio maintenance procedure per 6-month consecutive period (routine prophy is Class I; perio prophy is Class II)
Fluoride Treatments	1 per consecutive 12 months for participants younger than age 14
Histopathologic Exams	Payable if the biopsy is covered; No coverage for other diagnostic tests
X-rays (routine)	Bitewings: 1 set in any consecutive 12 month period; Limited to a maximum of 4 films per set
X-rays (non-routine)	Full mouth or Panorex: 1 per 60 consecutive months
Periapical x-rays	4 in 12 consecutive months if not performed in conjunction with an operative procedure
Intraoral occlusal x-rays	2 in 12 consecutive months
Models	Not covered
Fillings	1 per tooth per 12 consecutive months (applies to replacement of identical surface fillings only)
Sealants	1 treatment per tooth per lifetime for children younger than age 14 only; Payable on unrestored permanent bicuspid or molar teeth only
Minor Perio (non-surgical)	Root planing – 1 per quadrant per 36 consecutive months
Perio Surgery	1 per 36 consecutive months per area of the mouth (same service)
Crowns and Inlays	Replacement limited to 1 per 84 consecutive months; Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges; Replacement must be indicated by major decay
Bridges	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired; Benefits are based on the amount payable for non-precious metals; No porcelain or white/tooth colored material on molar crowns or bridges
Dentures and Partials	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired
Relines, Rebases	Covered if more than 12 months after installation; 1 per 36 consecutive months
Adjustments	Covered if more than 12 months after installation; 1 per 12 consecutive months
Repairs - Bridges	Covered if more than 12 months after installation
Repairs - Dentures	Covered if more than 12 months after installation.
Endodontics	Root canal re-treatment 1 per 24 consecutive months, if necessity demonstrated

Benefit Exclusions:

- Services performed primarily for cosmetic reasons; Replacement of a lost or stolen appliance;
- Initial placement of a full or partial denture unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan; removal of only a permanent third molar will not qualify for an initial or replacement denture or bridge;
- Overdentures, personalization, precision or semi-precision attachments;
- Replacement of a bridge, denture or crown within 84 months following its initial date of insertion;
- Replacement of a bridge, denture or crown which can be made useable according to dental standards;
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion, the restoration of teeth which have been damaged by erosion, attrition or abrasion; bite registration; or bite analysis;
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
- Core buildup, labial veneers; Precious or semi-precious metals for crowns, bridges, pontics and abutments; crowns and bridges other than stainless steel or resin for participants under 16 years old;
- Implants are excluded with the exception of the prosthesis over the implant (Prosthesis being the crown, bridge or denture placed over the implant post)
- Bite registrations; precision or semi-precision attachments; splinting; Surgical implant of any type including any prosthetic device attached to it;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards; Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Procedures for which a charge would not have been made in the absence of coverage, for which the person is not legally required to pay;
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service;
- Experimental or investigational procedures and treatments; Procedures which are not necessary and which do not have uniform professional endorsement;
- Any injury resulting from, or in the course of, any employment for wage or profit; Any sickness covered under any workers's compensation or similar law;
- Reasonable and Customary other that the defined percentile;
- IV sedation or general anesthesia, except when medically or dentally necessary and when in conjunction with covered complex oral surgery;
- Fees charged for broken appointments, claim form submission or sterilization;
- Services not included in the list of covered dental expenses, unless Connecticut General agrees to accept such expense as a covered dental expense, in which case payment will be made consistent with similar services which would provide the least expensive professionally satisfactory result;
- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture; Replacement of teeth beyond the normal complement of 32;
- Prescription drugs; Athletic mouth guards; Myofunctional therapy;
- Charges for travel time; transportation costs; or professional advice given on the phone;
- Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
- Any procedure, service, or supply which may not reasonably be expected to successfully correct the covered person's dental condition for a period of at least three years, as determined by CG; Temporary, transitional or interim dental services; Diagnostic casts, diagnostic models, or study models;
- Any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of ($100.00 - $200.00) per 12 consecutive month period);
- Procedures that are a covered expense under any other medical plan which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
- Any charges, including ancillary charges, made by hospital, ambulatory surgical center or similar facility;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law; or an uninsured motorist insurance law

HUMANA SPECIALTY BENEFITS
DENTAL ACCESS PLAN
09/01/2011 - 08/31/2012

Welcome to *Dental Access*

Humana Specialty Benefits is pleased to offer you and your family an innovative option in dental benefits called *Dental Access*. Preventive dental care is an important part of everyone's health care needs. *Dental Access* is designed to meet your needs by providing affordable coverage and reducing the cost associated with maintaining good dental health.

Dental Access Offers:

Access

- Freedom to use any dentist with benefit incentives to use participating network providers
- Freedom for each family member to have their own dentist
- Immediate access to Specialists at fixed copayments
- No referral required for specialty care

Savings

- No deductibles
- Fixed member in-network copayments with no balance billing
- Scheduled reimbursement for out-of-network dental services
- No benefit waiting periods

Convenience

- No claims forms for in-network services
- No pre-authorization needed to change dentist or to use non-participating providers

Dental Access provides the protection, flexibility and the coverage you and your family desire. The plan offers both in-network and out-of-network benefits, that gives you and your family the ability to receive care from any dentist in the community. While most of the time there will be higher out-of-pocket costs for care obtained out-of-network, the plan provides you the comfort of having this flexibility.

In-Network Coverage

Private practice dentists who contract with Humana Specialty Benefits provide treatment and services for you and your family. These dentists agree to provide the comprehensive benefits outlined in your dental plan and to accept the Humana Specialty Benefits fee schedule. Upon enrolling in the plan, you may seek treatment from any dentist listed in the network directory. Your dentist will charge specific copayments for covered procedures. This means fewer out-of- pocket expenses for you when using your in-network coverage. See the Schedule of Benefits for exact copayments and reimbursements per dental procedure.

The In-Network Advantage

- Preventive and diagnostic services covered at 100 percent, including routine cleanings, examinations, X-rays, fluoride treatments and emergency palliative treatment (Office visit copayment may apply)
- Coverage for restorative and specialty care with fixed copayments
- Flexibility to choose any network dentist at any time
- Family Choice, which allows each family member to select a different general care dentist
- Immediate specialty access
- Quality assessment of participating dental offices

Humana Specialty Benefits is very concerned with providing you and your family with access to quality care and therefore takes the appropriate measures to verify the professional credentials of dentists applying for participation in the Humana Specialty Benefits network. On-site quality assurance inspections are performed on participating dental offices on an annual basis.

Out-Of-Network Coverage

If you should decide to seek services outside of Humana Specialty Benefits network of participating dental providers, you would simply receive dental care from any licensed, practicing dentist. You would pay for the treatment rendered, complete a claim form, and submit the form to Humana Specialty Benefits for direct reimbursement to you of approved claims. There are no deductibles or waiting periods to receive coverage. Refer to Benefits, Limitations and Exclusions for a detailed review of benefits. **A fixed dollar amount is reimbursed on each procedure. The applicable Preventive & Diagnostic Office Visit Copayment is deducted from the maximum reimbursement amount for preventive and diagnostic procedures.**

Your responsibility under this option includes any cost that remains after the insurance reimbursement and maximum benefit limitations. Your plan also covers a portion of the cost associated with emergency dental care that you may receive from a non-participating provider.

HUMANA SPECIALTY BENEFITS
DENTAL ACCESS PLAN
09/01/2011 - 08/31/2012 *(cont'd)*

BENEFIT SUMMARY

Below is a brief summary of the dental benefits under the *DENTAL ACCESS* plan. This is provided as an overview document. Details about your coverage are outlined in your Schedule of Dental Benefits. Should there be any difference between this summary and the Benefits Schedule, the terms and conditions of the Benefits Schedule will prevail.

DENTAL ACCESS		
	In-Network	**Out-of-Network**
Benefit Level	See Benefit Schedule	Schedule Reimbursements
Preventative & Diagnostic Office Visit Co-pay	None	None
Annual Deductible	$0.00	$0.00
Annual Benefit Maximum	Unlimited	Unlimited

BENEFIT SUMMARY FOR COVERED DENTAL SERVICES	You Pay Humana Specialty Benefits Provider	Humana Specialty Benefits Reimburses You
PREVENTIVE & DIAGNOSTIC SERVICES		
Periodic Oral Examination*	No charge	$24.00
Bitewing X-rays – Four*	No charge	$27.00
Panoramic Film*	No charge	$50.00
Prophylaxis – Adult*	No charge	$45.00
Prophylaxis – Child*	No charge	$30.00
Fluoride – Child (including prophylaxis)*	No charge	$35.00
Sealants (permanent molars only)*	No charge	$23.00
BASIC SERVICES		
Amalgam Filling – Two Surface	$0.00	$52.00
Composite Filling – Two Surface Anterior	$0.00	$52.00
Prefabricated Steel Crown – Primary	$90.00	$19.00
Pulp Cap – Direct (excluding final restorations)	$0.00	$23.00
Root Canal – Bicuspid	$0.00	$289.00
Scaling and Root Planning – Per Quad (4+ teeth per quad)*	$0.00	$79.00
MAJOR SERVICES		
Crown-Porcelain Fused To Noble Metal	$354.00	$136.00
Complete Full Upper Dentures*	$472.00	$132.00

ORTHODONTIC COVERAGE		
Children Coverage	$3,035 maximum fee	$365.00
Adult Coverage	$3,325 maximum fee	$165.00

Services indicated with an asterisk (*) are subject to frequency and/or age limitations. Consult your Benefits Schedule for a complete list of these frequencies, limitations and exclusions that apply.

This material is a brief outline of benefits and covered services. The full Schedule of Benefits with a complete explanation of services, exclusions, and limitations will be included in your enrollment book.

HUMANA SPECIALTY BENEFITS DHMO PLAN 09/01/2011 - 08/31/2012 *(cont'd)*

Welcome to the Humana Specialty Benefits DHMO Dental Program

Regular professional dental care is important to maintaining healthy teeth and gums. With rising dental fees, it can also be quite expensive.

Your selection of the **DHMO** Dental Program will provide professional dental care while helping you control dental expenses.

If you enroll in dental coverage, you must remain in the program selected for a period of 12 months.

With the **DHMO** program, you have coverage for preventive, basic and major services, and you can take advantage of:

- **Lowest payroll deduction option**
- **No deductibles**
- **No annual maximum**
- **Generally lower out-of-pocket expenses than a traditional program**

  (See your Schedule of benefit copayments for more details.)

Choice of Dentists

Humana DHMO contracts with dentists in the community to provide quality care to our members. To receive benefits, you and each of your dependents must select a dental facility from the Humana DHMO list of participating dental offices. Dentists undergo a thorough review process prior to participation in the network. A licensed general dentist and staff of professional auxiliaries operate each office. If you wish, you may select a different dentist for each covered dependent so that each covered dependent can receive dental care where it is most convenient.

Making an Appointment with your Dentist

You may schedule appointments by calling the dental office you selected after your effective date of coverage. When you call to schedule your appointment, notify the office that you are a member of the Humana Specialty Benefits dental plan.

Call **(800) 342-5209** if you are not certain about your dental provider selection.

Changing your Selection of Dentist

Members may wish to transfer to another participating dental office or provider. Transfer requests may be made in writing to Humana Specialty Benefits or may be requested by calling Humana Specialty Benefits' Member Support Department at **(800) 342-5209**. Outstanding balance must be cleared before a transfer request will be honored. Requests received by Humana Specialty Benefits during the first 15 days of the month will become effective the first of the following subsequent month. Members may not be seen at 2 different participating dental offices during the same one-month period. Humana Specialty Benefit) may open and close enrollment at any participating dental offices and providers from time to time.

Specialist Care

Certain dental procedures require the services of a specialist (i.e. some oral surgery, endodontics, periodontics and pedodontics). In those cases, you must seek treatment from Humana Specialty Benefits specialty providers to receive appropriate discounted fees. A referral is needed from your general dentist in order to receive services from a specialist in the DHMO network. Access to orthodontic discounts does not require a referral!

OPTUMHEALTH
VISION BENEFITS SUMMARY
09/01/2011 - 08/31/2012

Provider Locator

With OptumHealth Vision you are able to choose from network private practice providers and retail chain providers. Prior to enrolling in or using the OptumHealth Vision vision program, if you would like to identify a network provider, visit OptumHealth Vision's Website – www.myoptumhealthvision.com and provide locator or call OptumHealth Vision's Provider Locator Service at **1-800-839-3242** and follow the voice prompts:

- Enter the primary insured's unique identification number
- Enter the ZIP code for the area you wish to check
- After each entry, the system will repeat what you have entered and ask that you "Press 1" if correct, or "Press 2" if incorrect
- The system will then identify up to three network providers in the requested ZIP code area
- If you wish to hear the selections again, "Press 1". To enter another five-digit ZIP code, "Press 2"

Prior to using your benefits at a network provider, please call the provider and make an appointment. Please inform the provider that you are a OptumHealth Vision participant.

PLEASE NOTE: If there are differences in this document and the Group Policy, the Group Policy is the governing document. Please retain this Benefit Summary and Vision Care Program description that includes detailed benefit information and instructions on how to use the program. Customer Service is available toll-free at ***1-800-638-3120*** *from 8:00 am to 11:00 pm, Monday through Friday, and from 9:00 am to 6:30 pm on Saturdays.*

ID cards will be issued to all enrollees.

Important to Remember:

- Always identify yourself as a OptumHealth Vision participant when making your appointment. This will assist your provider in obtaining a claim authorization number prior to your visit.
- Benefits available every 12 months, based on last date of service.
- Your $150 contact lens allowance is applied to the fitting/ evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30, you will have $120 towards the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.

The following Services and Materials are excluded from coverage under the Policy:

1. Post cataract lenses
2. Non-prescription items
3. Medical or surgical treatment for eye disease, that requires the services of a physician
4. Worker's Compensation services or materials
5. Services or materials that the patient, without cost, obtains from any governmental organization or program
6. Services or materials that are not specifically covered by the Policy
7. Replacement or repair of lenses and/or frames that have been lost or broken
8. Cosmetic extras, except as stated in the Policy's Table of Benefits

OPTUMHEALTH VISION BENEFITS SUMMARY 09/01/2011 - 08/31/2012 *(cont'd)*

CITY OF ATLANTA – Program Year Effective 09/01/2011 - 08/31/2012 – Underwritten by United HealthCare Insurance Company

BENEFITS AT A OPTUMHEALTH VISION NETWORK PROVIDER	
COMPREHENSIVE VISION EXAM ($15 copay; Once Every 12 Months)	A vision examination is provided by a network optometrist or ophthalmologist, after applicable copay.
MATERIALS ($25 copay)	The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.
PAIR OF LENSES (for eyeglasses) (Once Every 12 Months) • Standard single vision • Standard lined bifocal • Standard lined trifocal • Standard lenticular	**Standard scratch-resistant coating, tints and UV are covered-in-full.** **Lens Options** – Options such as progressive lenses, polycarbonate lenses and anti-reflective coating may be available at a discount.
FRAMES (Once Every 12 Months)	Receive a $50 wholesale frame allowance (approximate retail value of $120 to $150) at private practice providers, or a minimum $130 frame allowance at retail chain providers.
CONTACT LENSES (in lieu of eyeglasses) (Once Every 12 Months) • Covered-in-full elective contact lenses • All other elective contacts • Necessary contact lenses*	The fitting/evaluation fees, contacts (including disposable s), and up to two follow-up visits are covered-in-full (after applicable copay) for many popular brands, such as Acuvue by Johnson & Johnson and Optima by Bausch & Lomb. If covered disposable contact lenses are chosen, up to 6 boxes (depending on prescription) are included when obtained from a network provider. It is important to note that OptumHealth Vision's covered-in-full contact lenses may vary by provider. A $150 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside of OptumHealth Vision's covered-in-full contacts (materials copay does not apply). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection. Covered-in-full (after applicable copay).
REFRACTIVE EYE SURGERY	OptumHealth Vision participants receive access to discounted refractive eye surgery from numerous provider locations throughout the United States. To find a participating laser eye surgeon in your area, visit our Web site at www.myoptumhealthvision.com.

BENEFITS AT AN OUT-OF-NETWORK PROVIDER

SERVICE	AMOUNT
Exam	
Optometrist	up to $40
Ophthalmologist	up to $40
Lenses	
Single Vision	up to $40
Bifocal	up to $60
Trifocal	up to $80
Lenticular	up to $80
Frames	up to $45
Contact Lenses (in lieu of eyeglasses)	
Elective	up to $150
Necessary*	up to $210

If you choose an out-of-network provider, you will need to send your itemized receipts, with the primary-insured's unique identification number and the patient's name and date of birth, to:

OptumHealth Vision
P. O. Box 30978
Salt Lake City, UT 84130

Please note: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.

** Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery; To correct extreme vision problems that cannot be corrected with spectacle lenses; With certain conditions of anisometropia; With certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact OptumHealth Vision concerning the reimbursement that OptumHealth Vision will make before you purchase such contacts.*

RETIRED COST OF HEALTH COVERAGE

Retiree rates are calculated accordingly:

- If a retiree was hired prior to April 1, 1986, that retiree should pay the premium that is listed in the 30% column
- Anyone hired on or after April 1, 1986 but retired between September 2009 through August 31, 2010 should pay the premium that is listed in 40% column
- Anyone hired on or after April 1, 1986 but retired September 2010 forward should pay the premium listed in the 50% column

This will be effective September 2011.

RETIRED COST OF HEALTH COVERAGE *(cont'd)*

You and the City of Atlanta share the cost of your health insurance coverage. The cost of the coverage varies from year to year. Your costs for health coverage for 2011-2012 are as follows:

BLUE CROSS BLUE SHIELD

	30%		40%		50%	
	RETIREE COST	CITY COST	RETIREE COST	CITY COST	RETIREE COST	CITY COST
MONTHLY RATES - WITHOUT MEDICARE						
RETIREE ONLY	$159.90	$373.11	$213.21	$319.81	$266.51	$266.51
RETIREE AND CHILD(REN)	$279.83	$652.93	$373.10	$559.65	$466.38	$466.38
RETIREE AND SPOUSE	$399.75	$932.76	$533.01	$799.51	$666.26	$666.26
RETIREE AND FAMILY	$527.76	$1,231.45	$703.69	$1,055.53	$879.61	$879.61
BENEFICIARY CHILD(REN)	$119.93	$279.83	$159.90	$239.86	$199.88	$199.88
WIDOW(ER)	$204.62	$477.45	$272.83	$409.24	$341.04	$341.04
WIDOW(ER) AND CHILD(REN)	$324.54	$757.27	$432.72	$649.09	$540.91	$540.91
BLUE CROSS BLUE SHIELD – ANTHEM MEDICARE PREFERRED (PPO)						
RETIREE ONLY Medicare	$124.73	$291.04	$166.31	$249.46	$207.89	$207.89
RETIREE AND CHILD(REN) Medicare	$244.65	$570.86	$326.21	$489.31	$407.76	$407.76
RETIREE AND SPOUSE (1 Medicare)	$364.58	$850.69	$486.11	$729.16	$607.64	$607.64
RETIREE AND SPOUSE (2 Medicare)	$249.46	$582.08	$332.62	$498.92	$415.77	$415.77
RETIREE AND FAMILY (1 Medicare)	$492.59	$1,149.38	$656.79	$985.18	$820.99	$820.99
RETIREE AND FAMILY (2 Medicare)	$457.42	$1,067.31	$609.89	$914.84	$762.37	$762.37
BENEFICIARY CHILD(REN) Medicare	$124.73	$291.04	$166.31	$249.46	$207.89	$207.89
WIDOW(ER) Medicare	$124.73	$291.04	$166.31	$249.46	$207.89	$207.89
WIDOW(ER) AND CHILD(REN) Medicare	$244.65	$570.86	$326.21	$489.31	$407.76	$407.76

Note: Retirees and/or Spouses covered by parts A & B of Medicare, who enroll with BlueCross BlueShield are only eligible forBCBS – Anthem Medicare Preferred (PPO).

RETIRED COST OF HEALTH COVERAGE *(cont'd)*

You and the City of Atlanta share the cost of your health insurance coverage. The cost of the coverage varies from year to year. Your costs for health coverage for 2011-2012 are as follows:

KAISER PERMANENTE HMO

	30%		40%		50%	
	RETIREE COST	CITY COST	RETIREE COST	CITY COST	RETIREE COST	CITY COST
MONTHLY RATES - WITHOUT MEDICARE						
RETIREE ONLY	$131.59	$307.04	$175.45	$263.17	$219.31	$219.31
RETIREE AND CHILD(REN)	$230.28	$537.31	$307.04	$460.55	$383.79	$383.79
RETIREE AND SPOUSE	$328.98	$767.62	$438.64	$657.96	$548.30	$548.30
RETIREE AND FAMILY	$434.24	$1,013.22	$578.98	$868.47	$723.73	$723.73
BENEFICIARY CHILD(REN)	$131.59	$307.04	$175.45	$263.17	$219.31	$219.31
WIDOW(ER)	$131.59	$307.04	$175.45	$263.17	$219.31	$219.31
WIDOW(ER) AND CHILD(REN)	$230.28	$537.31	$307.04	$460.55	$383.79	$383.79
KAISER PERMANENTE SENIOR ADVANTAGE MEDICARE						
RETIREE ONLY Medicare	$91.02	$212.37	$121.36	$182.03	$151.70	$151.70
RETIREE AND CHILD(REN) Medicare	$281.06	$655.81	$374.75	$562.12	$468.44	$468.44
RETIREE AND SPOUSE (1 Medicare)	$229.23	$534.87	$305.64	$458.46	$382.05	$382.05
RETIREE AND SPOUSE (2 Medicare)	$182.03	$424.75	$242.71	$364.07	$303.39	$303.39
RETIREE AND FAMILY (1 Medicare)	$388.18	$905.74	$517.57	$776.35	$646.96	$646.96
RETIREE AND FAMILY (2 Medicare)	$320.25	$747.24	$427.00	$640.49	$533.75	$533.75
BENEFICIARY CHILD(REN) Medicare	$91.02	$212.37	$121.36	$182.03	$151.70	$151.70
WIDOW(ER) Medicare	$91.02	$212.37	$121.36	$182.03	$151.70	$151.70
WIDOW(ER) AND CHILD(REN) Medicare	$281.06	$655.81	$374.75	$562.12	$468.44	$468.44

Note: Retirees and/or Spouses covered by parts A & B of Medicare, who enroll with Kaiser Permanente are only eligible for Sr. Advantage. Others family members may enroll in the HMO.

RETIREE COST OF OPTIONAL DENTAL COVERAGE

You and the City of Atlanta share the cost of your optional dental insurance coverage. The cost of the coverage varies from year to year. Your costs for health coverage for 2011-2012 are as follows:

OPTIONAL DENTAL PLANS

Cigna Dental

	High Option (Orthodontics)						Low Option (No Orthodontics)					
	Retiree Cost	City Cost	Retiree Cost	City Cost	Retiree Cost	City Cost	Retiree Cost	City Cost	Retiree Cost	City Cost	Retiree Cost	City Cost
MONTHLY RATE	**30%**		**40%**		**50%**		**30%**		**40%**		**50%**	
RETIREE ONLY	$8.57	$20.01	$11.43	$17.15	$14.29	$14.29	$8.34	$19.47	$11.12	$16.68	$13.90	$13.90
RETIREE AND CHILD	$18.20	$42.46	$24.26	$36.39	$30.33	$30.33	$16.18	$37.75	$21.57	$32.36	$26.97	$26.97
RETIREE AND SPOUSE	$17.49	$40.81	$23.32	$34.98	$29.15	$29.15	$17.02	$39.71	$22.69	$34.03	$28.36	$28.36
RETIREE AND FAMILY	$28.78	$67.16	$38.38	$57.56	$47.97	$47.97	$25.69	$59.95	$34.26	$51.38	$42.82	$42.82
BENEFICIARY CHILD(REN)	$18.20	$42.46	$24.26	$36.39	$30.33	$30.33	$16.18	$37.75	$21.57	$32.36	$26.97	$26.97
WIDOW(ER)	$8.57	$20.01	$11.43	$17.15	$14.29	$14.29	$8.34	$19.47	$11.12	$16.68	$13.90	$13.90
WIDOW(ER) AND CHILD(REN)	$18.20	$42.46	$24.26	$36.39	$30.33	$30.33	$16.18	$37.75	$21.57	$32.36	$26.97	$26.97

Humana Specialty Benefits

	Access Managed Care (Orthodontics)						Pre-Select (No Orthodontics)					
	Retiree Cost	City Cost	Retiree Cost	City Cost	Retiree Cost	City Cost	Retiree Cost	City Cost	Retiree Cost	City Cost	Retiree Cost	City Cost
MONTHLY RATE	**30%**		**40%**		**50%**		**30%**		**40%**		**50%**	
RETIREE ONLY	$4.54	$10.58	$6.05	$9.07	$7.56	$7.56	$3.06	$7.14	$4.08	$6.12	$5.10	$5.10
RETIREE AND CHILD	$8.81	$20.55	$11.74	$17.62	$14.68	$14.68	$5.56	$12.98	$7.42	$11.12	$9.27	$9.27
RETIREE AND SPOUSE	$9.25	$21.59	$12.34	$18.50	$15.42	$15.42	$6.09	$14.20	$8.12	$12.17	$10.15	$10.15
RETIREE AND FAMILY	$14.00	$32.66	$18.66	$27.99	$23.33	$23.33	$9.43	$22.00	$12.57	$18.86	$15.72	$15.72
BENEFICIARY CHILD(REN)	$9.25	$21.59	$12.34	$18.50	$15.42	$15.42	$5.56	$12.98	$7.42	$11.12	$9.27	$9.27
WIDOW(ER)	$4.84	$10.28	$6.05	$9.07	$7.56	$7.56	$3.36	$7.14	$4.20	$6.30	$5.25	$5.25
WIDOW(ER) AND CHILD(REN)	$9.25	$21.59	$12.34	$18.50	$15.42	$15.42	$5.56	$12.98	$7.42	$11.12	$9.27	$9.27

RETIREE COST OF OPTIONAL VISION COVERAGE

Your costs for health coverage for 2011-2012 are as follows:

OPTIONAL OPTUM HEALTH VISION PLAN

MONTHLY RATE	Retiree Cost	City Cost
RETIREE ONLY	$4.80	$0.00
RETIREE AND CHILD	$10.56	$0.00
RETIREE AND SPOUSE	$10.06	$0.00
RETIREE AND FAMILY	$13.59	$0.00
BENEFICIARY CHILD(REN)	$5.76	$0.00
WIDOW(ER)	$4.80	$0.00
WIDOW(ER) AND CHILD(REN)	$10.56	$0.00

RETIREE LIFE INSURANCE
09/01/2011 - 08/31/2012

You make a great investment in your family. You spend time with them. You care for them, and if you're not there for them, you want them protected. As a City of Atlanta retiree receiving a pension benefit, you are eligible for life insurance coverage.

The following is an outline of the Life Insurance benefits that are available. This information is provided as an overview and does not constitute a contract. Please refer to the Life Insurance policy for detailed explanation of policy provisions.

Eligibility

To be eligible for this plan:

- You must be a retiree of The City of Atlanta or you must be a widow(er) of an employee or retiree covered by insurance at the time of your spouse's death
- You must have had life insurance coverage as an active employee at the time of retirement
- For Dependent Life insurance your spouse or children must not be full-time members of the armed forces of any country
- Widow(er) can not cover dependents

Retiree/Widow(er) Coverage

- $5,000
- Some grandfathered employees may have different amounts
- A retiree or widow(er) who terminates his/her coverage is not eligible to return to the City Plan in the future

Spouse and Dependents Coverage

- Dependents Life Insurance is also available and would provide the following coverage:
  - Spouse: $5,000
  - Child between birth and six months: $600
  - Child between six months and 26 years: $5,000
- All late applications will require medical underwriting approval by Greater Georgia Life
- A Surviving Spouse who is insured at the time an Employee or retiree passes away will be eligible to continue his/her $5,000 Life Insurance coverage

Beneficiary Designation Change

You may change your beneficiary at any time during the year by completing a Beneficiary Change Form and submitting it to the DHR Insurance Division.

If You Have Questions

If you have any questions about eligibility enrollment or life insurance coverage, contact the DHR Insurance Division at **(404) 330-6036.**

Greater Georgia Life Insurance Company

Greater Georgia Life Insurance Company (Greater Georgia Life) has earned a solid reputation for its quality products, expert resources, superior services, steady growth, innovation and strong financial performance. Founded in 1982, Greater Georgia Life is a leader in the life insurance market.

RETIREE LIFE INSURANCE
09/01/2011 - 08/31/2012 *(cont'd)*

Cost of Coverage – *Has Not Changed*

You and the City of Atlanta share the cost of your life insurance coverage. The City pays for $2.97 per $1,000 of benefit and you pay $0.70 per $1,000 of benefit. The City does not contribute toward the cost of Dependent Life Insurance and Additional Life Insurance. Your cost for Life Insurance is as follows:

Amount of Insurance	You Pay	The City Pays
$5,000	$3.50	$14.85

For grandfathered retirees with Frozen Plans elected prior to May 31st, 1967 that have amounts over $5,000 the cost of coverage is listed below:

AMOUNT OF INSURANCE ($)	YOU PAY ($)	THE CITY PAYS ($)
6,000	$4.20	$17.82
7,000	$4.90	$20.79
8,000	$5.60	$23.76
9,000	$6.30	$26.73
10,000	$7.00	$29.70

Note: All other retirees have a flat $5,000 benefit amount.

DEPENDENTS PLAN

Amount of Insurance	
Spouse:	$5,000
Children Birth – six months:	$600
Children six months – 26 years:	$5,000
Surviving Spouse (if enrolled prior to the employee passing away):	$5,000

Retiree Monthly Premium	
Spouse:	$4.00
Child:	$1.19

Surviving Spouse Monthly Premium
$10.00

A RETIREE OR WIDOW(ER) WHO TERMINATES HIS/HER COVERAGE IS NOT ELIGIBLE TO RE-ENROLL TO THE CITY PLAN IN THE FUTURE

CHANGES IN COVERAGE

Change In Family Status

You may change your health and/or dental insurance coverage during the open enrollment period. You can also change your coverage during the year, but only if the application to change coverage is submitted **within 31 days** of your family status change because of:

- marriage;
- divorce*;
- birth, legal adoption, placement for adoption or custody change of an eligible child;
- death of a spouse or eligible child, or a dependent's leaving the household as a result of a custody agreement;
- changes in the spouse's employment which affects his/her eligibility for benefits under another employer's group benefits plan; student; or
- Part A & B of Medicare become effective.

**Any one removed from the policy is entitled to COBRA (see Continuation of Coverage).*

**Coverage will be effective the date of the Change in Family Status. An adjustment of the premium for the level of coverage change will be deducted from your pension check.*

Call the Insurance Division at **(404) 330-6036** for a **Health Insurance Change Application Form**. Both you and your spouse (if applicable) must sign the form. Return the form to the DHR Insurance Division.

Option Changes

Option changes are permitted only during the open enrollment period. Changes made during the open enrollment period become effective on September 1, 2011.

If you move out of the service area covered by the HMO in which you are enrolled, you must request a change to another plan **within 31 days** of your move or at the next open enrollment.

If a plan listed in this brochure ceases operation, during the plan year, retirees will have a choice to move to another plan.

If you decide to move to a different plan, you must do so at Open Enrollment, unless you determine that KAISER SENIOR ADVANTAGE does not meet your needs. You may re-enroll (with 30 days prior notice) in one of the City Plans. Additionally, if you enroll in Part A and Part B of Medicare during the year, you should notify the Benefits Division. You may also change to Kaiser Senior Advantage at that time.

Surviving Beneficiaries

- A Surviving Beneficiary is eligible for coverage if they are eligible for Pension Benefits and were covered as dependents at the time of the employee's or retiree's death. A Surviving Beneficiary who terminates his/her coverage will not be eligible to return to the City Benefit Plan at any time in the future.
- A Surviving Beneficiary cannot add new dependents.
- A Surviving Beneficiary child must continue to submit Full Time Student Statements to be eligible for coverage. When the child is no longer eligible for a Pension Check, he/she will be eligible for continuation of coverage under COBRA. Contact the DHR Insurance Division at **(404) 330-6036.**

Continuation of Coverage

Information about continuing health care coverage under COBRA is in the back of the booklet.

Remember that converted coverage may not be the same as group coverage, and will be available to you at the individual rate, not at the group rate. For additional information, call the respective insurance company/HMO.

The HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), better known as the KASSEBAUM-KENNEDY LEGISLATION states:

If you cease to be an eligible dependent, or your COBRA eligibility terminates, A CERTIFICATE OF GROUP HEALTH PLAN COVERAGE WILL BE MAILED, by your Insurance Carrier/HMO to the last address on their file.

If you do not submit changes, you will be enrolled in your current coverage and you will not be allowed to change coverage from 09/01/2011 - 08/31/2012 unless there is a change in family status or you relocate out of the service area of the carrier.

THE FOLLOWING FACTS MAY ANSWER QUESTIONS YOU HAVE CONCERNING YOUR INSURANCE

NO INSURANCE

If you do not want health and/or dental insurance during 09/01/2011 – 08/31/2012, you must initial **NO COVERAGE on your application or select NO COVERAGE if using Self-Service.**

COVERAGE FOR MENTAL OR PHYSICALLY DISABLED DEPENDENT

To provide coverage for a dependent who is incapable of self-support because of a mental or physical incapacity, a retiree must provide a completed *Physician Verification* of permanent disability. This form is available in the Insurance Division of DHR.

CHANGE OF ADDRESS

You should notify the Pension Division of your change of address to insure that you receive all notifications sent to retirees and to correct the City of Atlanta records.

PENSION DEDUCTIONS

As a retiree, your share of health/dental insurance will be deducted from your pension check monthly. However, in the case of late Open Enrollments, deductions may be delayed. If this occurs, back premiums and/or refunds (if applicable) will be included in your pension check as soon as possible.

ID CARDS

After your Open Enrollment Application is processed, and an eligibility file is sent to each insurance carrier, your ID card and member booklet will be mailed to your home address by the selected insurance company. The ID card should be placed in your wallet for easy access at all times. Be sure to read the member booklet carefully, and keep it in a safe place for easy reference. The member booklet will provide detailed information on how to use your insurance benefits. You will not receive a new ID card unless you make a change in your coverage.

Reimbursable claims should be filed only with your insurance carrier, not the City of Atlanta.

NOTE: All members will receive separate cards for dental and vision coverage.

Please provide a copy of your and/or your spouse's Medicare Part A and B.

If you need medical care prior to receiving your new ID card, use a physician and/or hospital on your new Carrier list of providers.

PLEASE MAKE A COPY OF YOUR OPEN ENROLLMENT APPLICATION AND DOCUMENTATION THAT YOU SUBMITTED FOR YOUR RECORDS.

FREQUENTLY ASKED QUESTIONS

How do I enroll or update my enrollment information?

Visit the City's public website at www.atlantaga.gov. From the left navigation bar on your page, click on "Departments" – "Human Resources" – "Employee/Retiree Benefits" home page. From the top navigation bar go to "How Do I…" – "Employee/Retiree Benefits Home Page." Employees may also go directly to the Employee Self-Service application within Oracle to enroll.

What is my user name?

Your user name is your employee ID number. If you are a retiree, you may find this number on your pension check. If you cannot locate your employee ID number, please call the Help Desk at 404-330-6474. The Help Desk representative will ask a series of questions for validation purposes. The Help Desk will provide you with your user name which is usually your employee ID number.

What is my password?

You must contact the help desk for a password at 404-330-6474.

What do I do if I forget my password?

You need to call the Help Desk at 404-330-6474 to reset the password or click "Forgot Your Password" online from the "Employee/Retiree Benefits" Home Page. A valid COA email address is required.

I have not received my enrollment package. What do I do?

You can go online to www.atlantaga.gov and click on Departments-Human Resources – Employee/Retiree Benefits and choose the link for Active Employees Benefits Booklet or Retiree Benefits Booklet. You may also email the Benefits Division at COABenefits@atlantaga.gov.

How much time do I have to enroll?

The Open Enrollment Period is from June 27, 2011 through midnight July 18, 2011 for all active and retired City of Atlanta employees. Because employees and retirees are enrolling online, you have access to the system 24 hours daily through July 18, 2011, except June 30 and July 4.

Do I enroll online, complete and return my application?

No. If you enroll online you do not have to complete and send in your application, only supporting documentation to add any new dependent.

If I enroll online, what will I have for my records to prove I have enrolled or confirmed my benefits?

You can print a confirmation statement when you have completed your online enrollment.

What should I do if I do not have access to Oracle or if I do not see the "COA Employee Self Service" responsibility in my menu options when I log into the Oracle system?

Please call our Help Desk at 404-330-6474. The Help Desk will be able to authorize access.

FREQUENTLY ASKED QUESTIONS *(cont'd)*

Are there any major changes this year to be concerned about?

We consider this Open Enrollment as a passive enrollment period, which means that no significant changes were made to the Medical, Dental and Vision Plans.

What will be the effective dates of my new selections for coverage?

The option that you select will be effective September 1, 2011 and remain in effect until August 31, 2012 unless you have a qualifying life event. If there is a qualifying life event, you must enroll your dependent(s) **within 31 days** of the qualifying life event. Failure to do so may result in delayed benefits until Benefits Enrollment Period of 2011.

Am I required to make changes to my benefits?

If you do not wish to make changes for the new benefit plan year, you are not required to return an application.

When does all information have to be submitted to the Insurance Division?

All Open Enrollment applications with benefit changes are due to the Department of Human Resources (DHR) - Insurance Division no later than July 18, 2011. If you are completing the application online, Open Enrollment will close at 11:59 p.m. July 18, 2011.

What are the time frames associated with my current coverage vs. new coverage plans?

Your current coverage continues through August 31, 2011. The next Coverage Plan Year is September 1, 2011 – August 31, 2012.

What is the worst that could happen if I don't comply with Open Enrollment period guidelines?

You remain on the current plan you are on until August 31, 2012.

Do you have directions for enrolling online?

Yes. Please reference this document: Self-Service Instructions

When will the Open Enrollment Meetings be held this year?

Please reference this document: Open Enrollment Meetings on pg. 6

What are considered Qualifying Life Events?

Qualifying Life Events include newborn children, marriage, divorce, domestic partners, dependent loss of coverage and leave-of-absence without pay.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Portability Provision

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provides protection for employees and dependents who have pre-existing medical conditions or might be denied health coverage based on factors related to an individual's health. HIPAA includes changes that:

- Limit Exclusion for pre-existing conditions.
- Prohibit discrimination against employees and dependents based on their health status.
- Guarantee renewability and availability of health coverage to certain employers and individuals; and
- Protect many workers who lose health coverage by providing better access to individual health insurance coverage.

Under HIPAA the employer may impose a pre-existing condition exclusion with respect to an employee, dependent or beneficiary only if the following requirements are satisfied:

- A pre-existing condition exclusion must relate to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period prior to an individual's enrollment date;
- A pre-existing condition exclusion may not last for more than 12 months after an individual's enrollment date; and
- This 12-month period must be reduced by the length of time of the individual's prior creditable coverage, excluding coverage before any break in coverage of 90 days or more

When an Employee Terminates Coverage

HIPAA requires that your Insurance Carrier provide you (and your dependents) with certificates of coverage automatically upon termination of coverage.

Special Enrollment Periods

There are special enrollment periods for you and your dependents who:

- Originally declined coverage because of other coverage, and
- Who exhausted COBRA benefits, lost eligibility for prior coverage, or employer contributions toward coverage were terminated, and
- An individual declining coverage must certify in writing that they are covered by another health program when they initially decline coverage under this group in order to later qualify under this special enrollment. A person declining coverage will be given notice of the consequences when they originally decline coverage.

In addition there are also special enrollment periods for new dependents resulting from marriages, births or adoptions. An unenrolled member may enroll **within 31 days** of such a special qualifying event.

Important Notes

- Individual or dependents must request coverage within 31 days of qualifying event (i.e. marriages, exhaustion of COBRA, etc.).
- Evidence of prior creditable coverage is required.

Please refer to your benefit booklet for more information concerning Portability Provisions and Requirements.

CONTINUATION OF COVERAGE NOTICE

Under COBRA – the Consolidated Omnibus Reconciliation Act of 1985, Title X, terminated employees and their eligible dependents may continue group health plan coverage. We urge you to read this description of the "continuation coverage" option carefully, and to make sure you and your spouse read and understand the rights and responsibilities in connection with this continuation of coverage. Both you and your spouse must sign the front page of this enrollment application.

The Benefits

If you are currently covered under The City of Atlanta Health Plan, you will be entitled to continue your and your family's Health Plan coverage for up to 18 months from the date coverage would have terminated because of voluntary or involuntary termination. If a qualified beneficiary is deemed disabled for Social Security, at the date of the qualifying event, or within the first 60 days following the qualifying event, the continuation coverage period is 29 months for all the members of your family who have elected COBRA. The 18-month period may be extended also if other events (such as a death or divorce) occur during that 18-month period. Employees discharged because of "gross misconduct" would not be eligible for continuation of coverage. Dependents who no longer qualify as dependents under the City of Atlanta Health Plan are eligible to apply for continuation of coverage. If you should die or become divorced, and if your spouse and dependents are covered by the City of Atlanta Health Plan at that time, they will be entitled to continue health coverage for up to 36 months. Continuation coverage is also available for your children for up to 36 months. If an Eligible Person is 60 years old on the date COBRA continuation coverage started COBRA coverage may extend up to the time of Medicare eligibility. If you have a new born child, adopt a child or have a child placed in your home pending adoption (for whom you have financial responsibility), while your COBRA continuation is in effect, you may add this child to your coverage.

The Cost

Continuation of coverage is optional on the part of the employee or dependent. Those who elect continuation of coverage will be required to pay 102% of the total monthly group premium for the applicable class of coverage. For the extended disability coverage, employees may be required to pay up to 150% of the monthly group premium for coverage during the 19th through the 29th month. Persons 60 years old on the date of COBRA eligibility may be required to pay up to 120% of the premium for extended time. There will be no contribution made by the City of Atlanta. Premiums are due monthly and in advance. You should note that your continuation coverage will stop if the premiums for this coverage are not paid on time.

If you elect to continue coverage new dependents may be added during the period of continuation on the same basis as they are added for active employees. If during continuation of coverage, health benefits and premium rates change, your coverage and costs will be affected accordingly. Should open enrollment occur during the period of your continuation you will retain your right to switch to a different option.

When Coverage Ends

If you or covered members of your family become entitled to Medicare or are covered under another employer-sponsored health plan, which does not limit coverage due to preexisting conditions, the continuation coverage from the City of Atlanta Health Plan will cease. In addition, your coverage will cease if City of Atlanta should terminate the Health Plan or you cease to pay premium. Once the period of coverage continuation has expired, anyone receiving continuation coverage will be eligible to convert to individual policies, as provided under the City of Atlanta Plan.

What You Must Do

You or your spouse or dependents must notify the DHR Insurance Division when your dependent child, reaches the maximum age under the Plan, or in the event you become divorced. It is important that you notify us of your or your dependents loss of Plan eligibility promptly–in advance, if possible, but no later than 60 days from the date coverage would otherwise have terminated in order to be eligible to elect continuation coverage. Within 14 days after the end of the month in which you notified the DHR Insurance Division, you or your eligible dependents will be mailed information and forms regarding continuation of coverage. You or your dependent must return the completed election forms within 60 days. If continuation of coverage is selected within 60 days you or your dependent will then have an additional 45 days to pay the applicable premium, retroactive to the date coverage would otherwise have terminated.

If you would like further information on continuation coverage under the City of Atlanta Health Plan, please contact the DHR Insurance Division at **(404) 330-6036**.

Conversion Privilege

When your group health insurance ends due to termination of employment with the City of Atlanta or due to expiration of COBRA continuation of health care coverage under the group contract you may apply for converted health coverage. For additional information contact the DHR Insurance Division **(404) 330-6036.**

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), better known as the KASSEBAUM-KENNEDY LEGISLATION.

If you terminate your employment with the City, or your COBRA eligibility terminates, A CERTIFICATE OF GROUP HEALTH PLAN COVERAGE will be mailed by your Insurance Carrier/HMO, to the last address on their file.

If you are a new employee, have previously waived your health insurance, or are adding a dependent other than a new born (or child placed in your home pending adoption), you should provide copies of the CERTIFICATE OF GROUP HEALTH PLAN COVERAGE issued to you or your dependents, by the previous employer(s) for CREDITABLE PRIOR COVERAGE.

GLOSSARY

Application: A signed statement of facts requested by the company on the basis of which the company decides whether or not to issue a policy. This then becomes part of the health insurance contract when the policy is issued.

Approved Amount: The amount determined by the Medicare carrier to be reasonable and fair for each service.

Beneficiary: The person designated or provided for by the terms to receive the proceeds upon the death of the insured.

Benefit Package: A collection of specific services or benefits that the HMO and Indemnity is obligated to provide under terms of its contracts with subscriber groups or individuals.

Benefit Period: The period of time during which benefits are available, such as a year or for the lifetime of the contract.

Benefits: The amount payable by an insurance company for covered services.

Carrier: The insurance company responsible for processing claims; it may perform the carrier function on its own behalf, or for another entity who pays losses; under the Medicare program, for example, the Social Security Administration selects private insurance companies to administer Part B claims.

Claim: A demand to the insurer for the payment of benefits under the insurance contract.

Coinsurance: The fixed percentage of covered charges you must pay after any deductible has been subtracted. For example, if a plan pays 80 percent of covered charges (after applying any deductible), you would be responsible for the deductible and the 20 percent balance.

Consumer Choice Option (CCO): A health plan mandated in 1999 by the Georgia General Assembly. This plan allows members to nominate a non-network provider that will act as a part of the net-work. An employee who has selected the CCO may elect a qualified provider to render any covered services. Member is subject to normal rules and conditions that apply to a contracted network provider, i.e., reimbursement, usual customary and reasonable costs, and prescription drugs. Members will incur additional costs if they choose the CCO health plan.

Contingent Beneficiary: Person named to receive proceeds or benefits should an unforeseen event prevent the named Primary Beneficiary(ies) from collecting benefits (or insurance).

Conversion Privilege: A privilege granted in an insurance policy to convert to a different plan of insurance without providing evidence of insurability. The privilege granted by a group policy is to convert to an individual policy upon termination of group coverage.

Coordination of Benefits: Establishes procedures to be followed in the event of duplicate coverage thus assuring that no more than 100 percent of the costs of care are reimbursed to the patient.

Copayment: A fixed dollar amount you must pay for a service or benefit provided by a plan.

Coverage: The amount or extent to which any particular treatment or service is insured by a health provider.

Deductible: The amount of covered charges you must pay before the plan pays benefits, for example, calendar-year deductible and inpatient hospital deductible. Generally, no more than two or three family members must meet the calendar-year deductible. However, some plans have a family calendar-year deductible, which can be met by any or all of those covered.

Dental Care: Coverage may include routine diagnostic and preventive services and one or more of the following treatment services: restorative, crown and bridge, endodontic, oral surgery, periodontal, prosthetic, and orthodontic. Some prepaid plans (DMOs) limit coverage to preventive services for children.

Disability: A limitation of physical or mental functional capacity resulting from sickness or injury. It may be partial or total. (See also Partial Disability and Total Disability.)

Domestic Partnership: A union in which two individuals (unrelated by blood) of the opposite or same sex choose to share their lives in a close and committed relationship of mutual caring; who live together and have signed a Declaration of Domestic Partnership in which they have agreed to be jointly responsible for basic living expenses incurred during the Domestic Partnership.

Effective Date: The date on which the insurance under a policy begins.

Eligibility Period: A specified length of time, frequently 30 days following the eligibility date during which an individual member of a particular group will remain eligible to apply for insurance under a group life or health insurance policy without evidence or insurability.

Eligible Date: The date on which an individual member of a specified group becomes eligible to apply for insurance under the (group life or health) insurance plan.

Eligible Employees: Those members of a group who have met the eligibility requirements under a group life or health insurance plan.

Evidence of Insurability: Any statement of proof of a person's physical condition and/or other factual information affecting his/her acceptance for insurance.

Exclusions: Charges, services, or supplies that are not covered. A plan does not provide or pay for excluded items, nor do charges for them apply toward deductibles and catastrophic limits.

Flexible Spending Account (FSA): A benefit option that reimburses employees for certain expenses they incur. Money is deducted from pay checks on a pre-tax basis. It most often covers reimbursements for medical expenses not covered under other insurance, or child care expenses.

Grace Period: A specified period – thirty-one days – after a premium payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues.

HCFA: Health Care Financing Administration. The agency of the U.S. Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.

HIPAA: Health Insurance Portability and Accountability Act of 1996. A federal law which requires employers to provide certificates of coverage to minimize pre-existing condition exclusions.

Health Insurance: Protection that provides payment of benefits for covered sickness or injury. Included under this heading are various types of insurance such as accident insurance, disability income insurance, medical expense insurance, and accidental death and dismemberment insurance.

Health Maintenance Organization (HMO): An organization that provides a wide range of health-care services for a specified group at a fixed periodic payment. The HMO can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies, and hospital-medical plans.

Hospice Care: A coordinated program at home and/or on an inpatient basis, offering easing of the patient's pain and discomfort, and providing supportive care, for a terminally ill patient and the patient's family, provided by a medically supervised specialized team under the direction of a licensed or certified hospice-care facility or agency.

GLOSSARY *(cont'd)*

In-Network Provider: Selected physicians who furnish a comprehensive array of healthcare services. Under contractual agreement, doctors accept the insurance carriers "Usual, Customary and Reasonable" amounts, as payment-in-full.

Inpatient Services: The care provided while a bed patient is in a covered facility. Provides extra benefits for services not covered at all by the base plan, and that in some cases pays balances of services not covered completely by the base plan; most are characterized by large benefit maximums, ranging from $250,000 to no limit; above an initial deductible, major medical reimburse the major percentage of all charges for hospital, doctor, private nurses, and so on; the policyholder insurer pays the remaining co-insurance.

Managed Care: Health-care systems that integrate the financing and delivery of appropriate health-care services to covered individuals by arrangements with selected providers to furnish a comprehensive set of health-care services, explicit standards for selection of health-care providers, formal programs for ongoing quality assurance and utilization review and significant financial incentives for members to use providers and procedures associated with the plan.

Medicaid: State programs of public assistance to people, regardless of their age, whose income and resources are insufficient to pay for health care. Title 19 of the federal Social Security Act provides matching federal funds for financing state Medicaid programs, effective January 1, 1966.

Medicare Supplements (Medigap): Policies sold by insurance companies that help supplement the amounts not paid by the Medicare program for covered services.

Medicare: The government health insurance system for people over the age of 65 (and for certain other groups), created by the 1965 amendments to the Social Security Act. This includes new coverage for prescription drugs under Medicare Part D.

Miscellaneous Expenses (Ancillary Charges): Hospital charges (other than room and board) such as for x-rays, drugs, and laboratory fees.

Open Enrollment Period: The period of time stipulated in a group contract in which eligible of the group can choose a health plan alternative for the coming benefit year.

Out-of-Area Benefits: The scope of emergency benefits (and related limitations) available to HMO members while temporarily outside their defined service areas. Some HMOs offer unlimited out-of-area emergency coverage. Others impose a stated maximum annual dollar benefit. Emergency coverage is usually the only HMO benefit in the total benefit package for which members may need to file claim forms for reimbursement of their out-of-pocket expenditures for care.

Out-of-Network Providers: Physicians who do not participate in a contractual relationship, that provide services and care for a predetermined amount to a carrier's member.

Outpatient Services: The care provided to you in the outpatient department of a hospital, in a clinic or other medical facility, or in a doctor's office.

Partial Disability: The result of an illness or injury that prevents an insured from performing one or more of the functions of his or her regular job.

Participating Physician: A doctor or supplier who agrees to accept Medicare assignment on all claims under the medicare program. Agreement by which, under the contractual agreement, the doctors accept the insurance carriers usual, customary, and reasonable amount as payment in full.

Point-of-Service (POS): This product may also be called an open-ended HMO and offers a transition product incorporating features of both HMOs and PPOs. Beneficiaries are enrolled in an HMO but have the option to go outside the network for an additional cost.

Preadmission Certification: A procedure whereby (1) you or your doctor is required to contact your plan before your admission to a hospital, and (2) your plan determines the appropriateness of the admission and the length of stay by using established medical criteria.

Preexisting Condition: A physical and/or mental condition of an insured that first manifested itself prior to the issuance of his or her policy or that existed prior to issuance and for which treatment was received.

Preferred Provider Organization (PPO): A group of physicians and/or hospitals who contract with an employer to provide services to their employees. In a PPO the patient may go to the physician of his/her choice, even if that physician does not participate in the PPO, but the patient receives care at a lower benefit level.

Premium: The fee you must pay (monthly, biweekly, quarterly) on a regular basis for your enrollment in a plan.

Prescription Drugs: Outpatient drugs and medicines which, by United States law, cannot be obtained without a doctor's prescription.

Primary Care Network: The structure for these networks will vary considerably depending on the specific network. It may range from a loose association of physicians in a geographic area with a limited sharing of overhead, patient referral, call, etc. to a more structured association with commonly owned satellite clinics, etc.

Primary Care Physician (PCP): Provide treatment of routine injuries and illness and focuses on preventative care. Serves as gate-keeper for managed care. The American Academy of Family Practice defines primary care as "care from doctors trained to handle health concerns not limited by problem origin, organ systems, gender or diagnosis.

Prior Authorization: Procedure used in managed care to control utilization of services by prospective reviewing and approval.

Providers: Those institutions and individuals who are licensed to provide health care services (for example, hospitals, skilled nursing facilities, physicians, pharmacists, etc.). Providers in a defined service area are principally owned by, affiliated with, employed by, or under contract to an HMO.

Service Area: The geographic area where prepaid plan (HMO) providers and facilities are available to you. This area would be the same as, or within, the plan's enrollment area.

Total Disability: An illness or injury that prevents an insured person from continuously performing every duty pertaining to his or her occupation or engaging in any other type of work. (This wording varies among insurance companies.)

UCR (Usual, Customary, and Reasonable): A maximum payment allowed for a given medical service based on a statistical formula calculated by an insurance company to determine the amount it will pay on a given medical service.

Waiting Period: The length of time an insured must wait from his or her date of enrollment or application for coverage to the date his or her insurance is effective.

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CHANGE OF ADDRESS FORM

CITY OF ATLANTA

Retiree Change of Address Notification

NAME (PLEASE PRINT)

SOCIAL SECURITY NUMBER

I hereby request that my MAILING ADDRESS FOR PENSION PAYMENTS be changed as follows:

OLD ADDRESS _____

_____

_____

NEW ADDRESS _____

_____

_____

PLEASE RETURN THIS FORM TO:

(Fire and Police Pension Plan)
ASI
2187 Northlake Parkway
Building 9, Suite 106
Tucker, GA 30084-4149

(General Pension Plan)
City of Atlanta
General Pension Division
55 Trinity Ave. S.W., Suite 1600
Atlanta, Georgia 30335-0317

_____
RETIREE SIGNATURE

_____
DATE

_____
NOTARY PUBLIC SIGNATURE

_____
DATE

NOTARY STAMP

** The Change of Address Form must be notarized.

**** If you would like your PENSION CHECK to be DEPOSITED DIRECTLY INTO YOUR BANK ACCOUNT every month, please request a PENSION DIRECT DEPOSIT AUTHORIZATION form by calling the Pension Division at **(404) 330-6260.**

DIRECT DEPOSIT FORMS MUST BE NOTARIZED.

City of Atlanta
Department of Human Resources
Insurance Division
404.330.6036